Health & Human Services Committee

Tuesday, February 9, 2016
11:30 AM – 2:30 PM
Morris Hall

Steve Crisafulli
Speaker

Jason Brodeur
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

(AMENDED 2/5/2016 4:20:44PM)

Amended(1)

Health & Human Services Committee

Start Date and Time:	Tuesday, February 09, 2016 11:30 am
End Date and Time:	Tuesday, February 09, 2016 02:30 pm
Location:	Morris Hall (17 HOB)
Duration:	3.00 hrs

Consideration of the following bill(s):

CS/HB 563 Temporary Cash Assistance Program by Children, Families & Seniors Subcommittee, Gaetz
HB 823 Ethical Marketing Practices for Substance Abuse Services by Rooney, Hager
HB 1083 Agency for Persons with Disabilities by Renner
HB 1245 Medicaid Provider Overpayments by Peters
HB 1313 Low-THC Cannabis for Medical Use by Brodeur, Steube
HB 1335 Long-term Care Prioritization by Magar
CS/HB 1411 Termination of Pregnancies by Health Care Appropriations Subcommittee, Burton

Consideration of the following bill(s) with proposed committee substitute(s):

HB 819 Sunset Review of Medicaid Dental Services by Diaz, J.
PCS for HB 819 -- Medicaid Dental Services

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Monday, February 8, 2016.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, February 8, 2016.

NOTICE FINALIZED on 02/05/2016 4:20PM by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 563 Temporary Cash Assistance Program
SPONSOR(S): Children, Families & Seniors Subcommittee, Gaetz
TIED BILLS: **IDEN./SIM. BILLS:** SB 750

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	8 Y, 4 N, As CS	Langston	Brazzell
2) Health Care Appropriations Subcommittee	9 Y, 2 N	Pridgeon	Pridgeon
3) Health & Human Services Committee		Langston	Calamas

SUMMARY ANALYSIS

Florida's Temporary Cash Assistance (TCA) Program provides cash assistance to needy families with children that meet the technical, income, and asset eligibility requirements. The purpose of the TCA Program is to help families become economically self-supporting so as to require minimal involvement by an efficient government.

The Department of Children and Families determines eligibility for the TCA program. To be eligible for the TCA Program, applicants must, among other things, be U.S. citizens or qualified non-citizens, reside in Florida, and be under the income threshold. To be eligible, a family must have a gross income of less than 185% of the Federal Poverty Level. When calculating eligibility, the earned income of a child who attends high school or the equivalent, and is 19 years of age or younger, is disregarded.

While an illegal or ineligible noncitizen may not receive TCA, his or her citizen or eligible noncitizen family members may receive TCA. When determining eligibility for the family members who meet citizenship requirements in a family that also has illegal or ineligible noncitizen members, only a pro-rata share of the illegal or ineligible noncitizen family member's income is counted.

CS/HB 563 amends s. 414.095(11)(b), F.S., to specify that the earned income of a child who attends high school or the equivalent is disregarded only if that child is under the age of 19, rather than 19 years old or younger. This change aligns the definition of a "child" with the definition of a "minor child" in s. 414.0252(8), F.S.

The bill also amends s. 414.095(3)(d), F.S., to count all of a noncitizen's income when determining a household's income eligibility. The bill treats the income of U.S. citizens and noncitizens (legal, ineligible, or illegal) who are mandatory family members the same for TCA eligibility. This will impact 149 households per month.

The bill is estimated to have a recurring positive fiscal impact on the TCA program of $239,518, annually, and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Temporary Assistance for Needy Families

Under the federal welfare reform legislation of 1996, the Temporary Assistance for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, and the Emergency Assistance program.[1] The law ended federal entitlement to assistance and instead created TANF as a block grant that provides states, territories, and tribes federal funds each year.[2] These funds cover benefits, administrative expenses, and services targeted to needy families.[3] TANF became effective July 1, 1997, and was reauthorized in 2006 by the Deficit Reduction Act of 2005.[4] States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.

Florida's Temporary Cash Assistance Program

The Temporary Cash Assistance (TCA) Program provides cash assistance to families with children under the age of 18 or under age 19[5] if full time high school students, that meet the technical, income, and asset requirements. The purpose of the TCA Program is to help families become economically self-supporting so as to require minimal involvement by an efficient government.[6]

Cash assistance is available to two categories of families: work-eligible (full-family cases) and child-only.[7] The TCA Program also provides monthly cash assistance to relatives who meet eligibility rules and have custody of a child under age 18 who has been court-ordered dependent by a Florida court and placed in their home though the relative caregiver program.[8]

Various state agencies and entities work together through a series of contracts or memorandums of understanding to administer the TCA Program. The Department of Children and Families (DCF) is the recipient of the federal TANF block grant.[9] DCF also determines eligibility and disperses benefits.[10]

Eligibility Determination

A person must meet all eligibility requirements to receive TCA benefits. DCF processes the initial application for TCA. The application may be submitted in person, online or through the mail.[11] To be eligible for the TCA Program applicants must, among other things:

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[1] 42 U.S.C. § 601 et seq.; 45 C.F.R. § 260.10 et seq.
[2] 42 U.S.C. § 602.
[3] 42 U.S.C. § 603.
[4] Pub. L. 109-171, s. 7101.
[5] Parents, children and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.
[6] S. 414.025(1), F.S.
[7] S. 414.045(1), F.S.
[8] S. 39.5085, F.S.
[9] Department of Children and Families Economic Self-Sufficiency Program Office, *Temporary Assistance for Needy Families State Plan Renewal October 1, 2014 – September 30, 2017,* Nov. 14, 2014, p. 5, available at www.dcf.state.fl.us/programs/access/docs/TANF-Plan.pdf (last visited February 5, 2016).
[10] Rule 65A-1.205(2)-(3), F.A.C
[11] Rule 65A-1.205(1), F.A.C

- Be U.S. citizens or qualified non-citizens;[12]
- Reside in Florida;
- Have a gross income of less than 185% of the Federal Poverty Level (FPL);[13] and
- Have a countable income that is not higher than the payment standard for the family size.[14]

The earned income of a child who attends high school or the equivalent, and is 19 years of age and younger, is disregarded.[15] However, the TCA program statute defines a minor child as an unmarried child under 18 years of age, or under 19 years of age if the child is a full-time student in a high school or the equivalent.[16]

The total income of U.S. citizens is counted in determining a family's eligibility.[17] Ineligible noncitizens[18] may not receive benefits; however, their family members who meet the citizenship requirement may be eligible. When determining eligibility for those family members who meet citizenship requirements, only a pro-rata share of the illegal or ineligible noncitizen family member's income is counted toward the total household income.[19]

Effect of the Bill

Earned Income by a Child for TCA Eligibility

The bill amends s. 414.095(11)(b), F.S., to require DCF to disregard the earned income of a child who attends high school or the equivalent if that child is under the age of 19, rather than 19 years old or younger. This change aligns the definition of a "child" with the definition of a "minor child" in s. 414.0252(8), F.S.

Noncitizen Income for TCA Eligibility

The bill amends s. 414.095(3)(d), F.S., to count all of a noncitizen's income, not only a pro-rata share, in calculating household income to determine elgibility. The income of U.S. citizens and noncitizens (legal, ineligible, or illegal) who are mandatory family members would be treated equally and this would increase some families' countable income. Families where the increase in considered income places them above the threshold for receiving benefits would no longer be eligible and would stop receiving TCA benefits. This change will affect an estimated 149 households per month.[20]

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Amends s. 414.095, F.S., relating to determining eligibility for temporary cash assistance.
Section 2: Reenacts s. 414.045, F.S., relating to cash assistance program.
Section 3: Provides an effective date.

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[12] S. 414.095(3), F.S. A qualified noncitizen includes an individual who is admitted to the United States as a refugee or who is granted asylum, a Cuban or Haitian entrant, or a noncitizen who has been admitted as a permanent resident. It also includes an individual who, or an individual whose child or parent, has been battered or subject to extreme cruelty in the United States by a spouse, a parent, or other household member, and has applied for or received protection under the federal Violence Against Women Act, if certain criteria are met.
[13] For 2016, 185% of the FPL for a family of two is $ 29,637 (or $ 2,469.75 per month); for a family four it is $ 44,955 (or $ 3,746.25 per month).
[14] S. 414.095, F.S.
[15] S. 414.095(11)(b), F.S.
[16] S. 414.0252(8), F.S.
[17] S. 414.085, F.S.
[18] S. 414.095(3), F.S. Ineligible noncitizens include nonimmigrant noncitizens, including tourists, business visitors, foreign students, exchange visitors, temporary workers, and diplomats.
[19] S. 414.095(3)(d), F.S.
[20] Id.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will reduce annual TCA expenditures through reduced payments to households that contain an illegal or ineligible noncitizen with income. DCF estimates 149 households per month would be impacted by this change. The estimated savings from this change is $239,518, annually.[21]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Approximately 149 households, monthly, will no longer be eligible to receive TCA as a result of the changes to the non-citizen income calculations.

D. FISCAL COMMENTS:

The Social Service Estimating Conference pursuant to s. 216.136, F.S., determines the annual need and forecasted expenditures for the TCA program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

[21] Department of Children and Families, *2016 Agency Legislative Bill Analysis-CS/HB 563*, January 28, 2016 (on file with Health and Human Services Committee staff).

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 20, 2016, the Children, Families, and Seniors Subcommittee adopted an amendment that narrowed the scope of the bill to focus solely on the eligibility determination, and what income is counted, for TCA. The bill was reported favorably as a committee substitute. This analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

A bill to be entitled

An act relating to the temporary cash assistance program; amending s. 414.095, F.S.; revising the consideration of income from illegal noncitizen or ineligible noncitizen family members in determining eligibility for temporary cash assistance; reenacting s. 414.045(1), F.S., relating to the cash assistance program, to incorporate the amendment made by the act to s. 414.095, F.S., in a reference thereto; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (d) of subsection (3) and subsection (11) of section 414.095, Florida Statutes, are amended to read:

414.095 Determining eligibility for temporary cash assistance.—

(3) ELIGIBILITY FOR NONCITIZENS.—A "qualified noncitizen" is an individual who is admitted to the United States as a refugee under s. 207 of the Immigration and Nationality Act or who is granted asylum under s. 208 of the Immigration and Nationality Act; a noncitizen whose deportation is withheld under s. 243(h) or s. 241(b)(3) of the Immigration and Nationality Act; a noncitizen who is paroled into the United States under s. 212(d)(5) of the Immigration and Nationality Act, for at least 1 year; a noncitizen who is granted

conditional entry pursuant to s. 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980; a Cuban or Haitian entrant; or a noncitizen who has been admitted as a permanent resident. In addition, a "qualified noncitizen" includes an individual who, or an individual whose child or parent, has been battered or subject to extreme cruelty in the United States by a spouse, a parent, or other household member under certain circumstances, and has applied for or received protection under the federal Violence Against Women Act of 1994, Pub. L. No. 103-322, if the need for benefits is related to the abuse and the batterer no longer lives in the household. A "nonqualified noncitizen" is a nonimmigrant noncitizen, including a tourist, business visitor, foreign student, exchange visitor, temporary worker, or diplomat. In addition, a "nonqualified noncitizen" includes an individual paroled into the United States for less than 1 year. A qualified noncitizen who is otherwise eligible may receive temporary cash assistance to the extent permitted by federal law. The income or resources of a sponsor and the sponsor's spouse shall be included in determining eligibility to the maximum extent permitted by federal law.

(d) The income of an illegal noncitizen or ineligible noncitizen who is a mandatory member of a family~~, less a pro rata share for the illegal noncitizen or ineligible noncitizen,~~ counts <u>in full</u> in determining a family's eligibility to participate in the program.

(11) DISREGARDS.—

(a) As an incentive to employment, the first $200 plus one-half of the remainder of earned income shall be disregarded. In order to be eligible for earned income to be disregarded, the individual must be:

1. A current participant in the program; or

2. Eligible for participation in the program without the earnings disregard.

(b) A child's earned income shall be disregarded if the child is a family member, attends high school or the equivalent, and is younger than 19 years of age ~~or younger~~.

Section 2. For the purpose of incorporating the amendment made by this act to section 414.095, Florida Statutes, in a reference thereto, subsection (1) of section 414.045, Florida Statutes, is reenacted to read:

414.045 Cash assistance program.—Cash assistance families include any families receiving cash assistance payments from the state program for temporary assistance for needy families as defined in federal law, whether such funds are from federal funds, state funds, or commingled federal and state funds. Cash assistance families may also include families receiving cash assistance through a program defined as a separate state program.

(1) For reporting purposes, families receiving cash assistance shall be grouped into the following categories. The department may develop additional groupings in order to comply

with federal reporting requirements, to comply with the data-reporting needs of the board of directors of CareerSource Florida, Inc., or to better inform the public of program progress.

(a) Work-eligible cases.—Work-eligible cases shall include:

1. Families containing an adult or a teen head of household, as defined by federal law. These cases are generally subject to the work activity requirements provided in s. 445.024 and the time limitations on benefits provided in s. 414.105.

2. Families with a parent where the parent's needs have been removed from the case due to sanction or disqualification shall be considered work-eligible cases to the extent that such cases are considered in the calculation of federal participation rates or would be counted in such calculation in future months.

3. Families participating in transition assistance programs.

4. Families otherwise eligible for temporary cash assistance which receive diversion services, a severance payment, or participate in the relocation program.

(b) Child-only cases.—Child-only cases include cases that do not have an adult or teen head of household as defined in federal law. Such cases include:

1. Children in the care of caretaker relatives, if the caretaker relatives choose to have their needs excluded in the calculation of the amount of cash assistance.

2. Families in the Relative Caregiver Program as provided in s. 39.5085.

3. Families in which the only parent in a single-parent family or both parents in a two-parent family receive supplemental security income (SSI) benefits under Title XVI of the Social Security Act, as amended. To the extent permitted by federal law, individuals receiving SSI shall be excluded as household members in determining the amount of cash assistance, and such cases shall not be considered families containing an adult. Parents or caretaker relatives who are excluded from the cash assistance group due to receipt of SSI may choose to participate in work activities. An individual whose ability to participate in work activities is limited who volunteers to participate in work activities shall be assigned to work activities consistent with such limitations. An individual who volunteers to participate in a work activity may receive child care or support services consistent with such participation.

4. Families in which the only parent in a single-parent family or both parents in a two-parent family are not eligible for cash assistance due to immigration status or other limitation of federal law. To the extent required by federal law, such cases shall not be considered families containing an adult.

5. To the extent permitted by federal law and subject to appropriations, special needs children who have been adopted pursuant to s. 409.166 and whose adopting family qualifies as a

needy family under the state program for temporary assistance for needy families. Notwithstanding any provision to the contrary in s. 414.075, s. 414.085, or s. 414.095, a family shall be considered a needy family if:

a. The family is determined by the department to have an income below 200 percent of the federal poverty level;

b. The family meets the requirements of s. 414.095(2) and (3) related to residence, citizenship, or eligible noncitizen status; and

c. The family provides any information that may be necessary to meet federal reporting requirements specified under Part A of Title IV of the Social Security Act.

Families described in subparagraph 1., subparagraph 2., or subparagraph 3. may receive child care assistance or other supports or services so that the children may continue to be cared for in their own homes or in the homes of relatives. Such assistance or services may be funded from the temporary assistance for needy families block grant to the extent permitted under federal law and to the extent funds have been provided in the General Appropriations Act.

Section 3. This act shall take effect July 1, 2016.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Eagle offered the following:

Amendment (with title amendment)

Between lines 151 and 152, insert:

Section 3. Subsection (1) and paragraph (a) of subsection (2) of section 414.065, Florida Statutes, are amended to read:

414.065 Noncompliance with work requirements.—

(1) PENALTIES FOR NONPARTICIPATION IN WORK REQUIREMENTS AND FAILURE TO COMPLY WITH ALTERNATIVE REQUIREMENT PLANS.—The department shall establish procedures for administering penalties for nonparticipation in work requirements and failure to comply with the alternative requirement plan. If an individual in a family receiving temporary cash assistance fails to engage in work activities required in accordance with s. 445.024, the following penalties shall apply. Prior to the

imposition of a sanction, the participant shall be notified orally or in writing that the participant is subject to sanction and that action will be taken to impose the sanction unless the participant complies with the work activity requirements. The participant shall be counseled as to the consequences of noncompliance and, if appropriate, shall be referred for services that could assist the participant to fully comply with program requirements. If the participant has good cause for noncompliance or demonstrates satisfactory compliance, the sanction shall not be imposed. If the participant has subsequently obtained employment, the participant shall be counseled regarding the transitional benefits that may be available and provided information about how to access such benefits. The department shall administer sanctions related to food assistance consistent with federal regulations.

(a)1. First noncompliance: temporary cash assistance shall be terminated for the family for a minimum of 1 month ~~10 days~~ or until the individual who failed to comply does so, whichever is later. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

2. Second noncompliance:

a. Temporary cash assistance shall be terminated for the family for 3 months ~~1 month~~ or until the individual who failed to comply does so, whichever is later. The individual shall be required to comply with the required work activity upon

completion of the 3-month penalty period before reinstatement of temporary cash assistance. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

b. Upon the second occurrence of noncompliance, temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first 3 months of the penalty period through a protective payee as specified in subsection (2).

3. Third noncompliance:

a. Temporary cash assistance shall be terminated for the family for 6 ~~3~~ months or until the individual who failed to comply does so, whichever is later. The individual shall be required to comply with the required work activity upon completion of the 6-month ~~3-month~~ penalty period, before reinstatement of temporary cash assistance. Upon meeting this requirement, temporary cash assistance shall be reinstated to the date of compliance or the first day of the month following the penalty period, whichever is later.

b. Upon the third occurrence of noncompliance, temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first 6 months of the penalty period through a protective payee as specified in subsection (2).

4. Fourth noncompliance:

a. Temporary cash assistance shall be terminated for the family for 12 months, or until the individual who failed to comply does so, whichever is later. The individual shall be required to comply with the required work activity upon completion of the 12-month penalty period and reapply before reinstatement of temporary cash assistance. Upon meeting this requirement, temporary cash assistance shall be reinstated to the first day of the month following the penalty period.

b. Upon the fourth occurrence of noncompliance, temporary cash assistance for the child or children in a family who are under age 16 may be continued for the first 12 months of the penalty period through a protective payee as specified in subsection (2).

5. This paragraph does not prohibit a participant from complying with the work activity requirements during the penalty periods imposed in paragraph (a).

(b) If a participant receiving temporary cash assistance who is otherwise exempted from noncompliance penalties fails to comply with the alternative requirement plan required in accordance with this section, the penalties provided in paragraph (a) shall apply.

(c) When a participant is sanctioned for noncompliance with this section, the department shall refer the participant to appropriate free and low-cost community services, including food banks.

If a participant fully complies with work activity requirements for at least 6 months, the participant shall be reinstated as being in full compliance with program requirements for purpose of sanctions imposed under this section.

(2) CONTINUATION OF TEMPORARY CASH ASSISTANCE FOR CHILDREN; PROTECTIVE PAYEES.—

(a) Upon the second or subsequent ~~third~~ occurrence of noncompliance, subject to the limitations in paragraph (1)(a), temporary cash assistance and food assistance for the child or children in a family who are under age 16 may be continued. Any such payments must be made through a protective payee or, in the case of food assistance, through an authorized representative. Under no circumstances shall temporary cash assistance or food assistance be paid to an individual who has failed to comply with program requirements.

Section 4. Subsections (3) through (7) of section 445.024, Florida Statutes, are renumbered as subsections (4) through (8), respectively, and a new subsection (3) is added to that section, to read:

445.024 Work requirements.—

(3) WORK PLAN AGREEMENT.—For each individual who is not otherwise exempt from work activity requirements, but before a participant may receive temporary cash assistance, the Department of Economic Opportunity, in cooperation with CareerSource Florida, Inc., the regional workforce boards, and the Department of the Department of Children and Families, must:

(a) Inform the participant, in plain language, and require the participant to assent to, in writing:

1. What is expected of the participant to continue to receive temporary cash assistance benefits.

2. Under what circumstances the participant would be sanctioned for noncompliance.

3. Potential penalties for noncompliance with work requirements in s. 414.065, including how long benefits would not be available to the participant.

(b) Work with the participant to develop strategies to assist the participant in overcoming obstacles to compliance with the work activity requirements.

Section 5. Subsection (4) of section 402.82, Florida Statutes, is renumbered as subsection (5), and a new subsection (4) is added to that section, to read:

402.82 Electronic benefits transfer program.—

(4) The department shall impose a fee for the fifth and each subsequent request for a replacement electronic benefits transfer card that a participant requests within a 12-month period. The fee must be equal to the cost to replace the electronic benefits transfer card. The fee may be deducted from the participant's benefits. The department may waive the replacement fee upon a showing of good cause, such as the malfunction of the card or extreme financial hardship.

Section 6. Paragraph (a) of subsection (2) of section 39.5085, Florida Statutes, is amended to read:

39.5085 Relative Caregiver Program.—

(2)(a) The Department of Children and Families shall establish, ~~and~~ operate, and implement the Relative Caregiver Program ~~pursuant to eligibility guidelines established in this section as further implemented~~ by rule of the department. The Relative Caregiver Program shall, within the limits of available funding, provide financial assistance to:

1. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.

2. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child, and a dependent half-brother or half-sister of that dependent child, in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.

3. Nonrelatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the nonrelative caregiver under this chapter. The court must find that a

proposed placement under this subparagraph is in the best interest of the child.

4. The relative or nonrelative caregiver may not receive a Relative Caregiver Program payment if the parent or stepparent of the child resides in the home. However, a relative or nonrelative may receive the payment for a minor parent who is in his or her care and for the minor parent's child, if both the minor parent and the child have been adjudicated dependent and meet all other eligibility requirements. If the caregiver is currently receiving the payment, the payment must be terminated no later than the first day of the following month after the parent or stepparent moves into the home. Before the payment is terminated, the caregiver must be given 10 days' notice of adverse action.

The placement may be court-ordered temporary legal custody to the relative or nonrelative under protective supervision of the department pursuant to s. 39.521(1)(b)3., or court-ordered placement in the home of a relative or nonrelative as a permanency option under s. 39.6221 or s. 39.6231 or under former s. 39.622 if the placement was made before July 1, 2006. The Relative Caregiver Program shall offer financial assistance to caregivers who would be unable to serve in that capacity without the caregiver payment because of financial burden, thus exposing the child to the trauma of placement in a shelter or in foster care.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:
An act relating to public assistance; amending s. 414.095, F.S.; revising the consideration of income from illegal noncitizen or ineligible noncitizen family members in determining eligibility for temporary cash assistance; reenacting s. 414.045(1), F.S., relating to the cash assistance program, to incorporate the amendment made by the act to s. 414.095, F.S., in a reference thereto; amending s. 414.065, F.S.; revising penalties for noncompliance with the work requirements for temporary cash assistance; limiting the receipt of child-only benefits during periods of noncompliance with work requirements; providing applicability of work requirements before expiration of the minimum penalty period; requiring the Department of Children and Families to refer sanctioned participants to appropriate free and low-cost community services, including food banks; amending s. 445.024, F.S.; requiring the Department of Economic Opportunity, in cooperation with CareerSource Florida, Inc., the regional workforce boards, and the Department of Children and Families, to develop and implement a work

plan agreement for participants in the temporary cash assistance program; requiring the plan to identify expectations, sanctions, and penalties for noncompliance with work requirements; amending s. 402.82, F.S.; requiring the Department of Children and Families to impose a replacement fee for electronic benefits transfer cards under certain circumstances; amending s. 39.5085, F.S.; revising eligibility guidelines for the Relative Caregiver Program with respect to relative and nonrelative caregivers; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 823 Ethical Marketing Practices for Substance Abuse Services
SPONSOR(S): Rooney, Jr. and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Committee		McElroy CM	Calamas CC
2) Appropriations Committee			
3) Judiciary Committee			

SUMMARY ANALYSIS

A recovery residence is a residential dwelling that provides a peer-supported, alcohol-free, and drug-free living environment. The Department of Children and Families administers a voluntary certification program for recovery residences and administrators, through private certification organizations. Courts have ruled that more rigorous regulatory programs, like licensure and zoning requirements, violate the Americans with Disabilities and the Fair Housing Acts.

The Florida Deceptive and Unfair Trade Practices Act (FDUTPA) and Florida's patient brokering act prohibit various types of deceptive and fraudulent business conduct, and apply to health care providers, substance abuse providers, recovery residences, and any other actor engaging in such practices.

House Bill 823 creates s. 397.355, F.S., to make certain unethical marketing practices by substance abuse treatment providers and recovery residences unlawful. Specifically, the bill prohibits false or misleading statements by these entities related to their products, goods, services, or location, and prohibits website coding that directs the reader to another website. The bill makes a violation of this prohibition a violation of FDUTPA. In addition, the bill imposes a civil penalty of not more than $5,000 per willful violation.

The bill amends FDUTPA to expands the circumstances under which a heightened civil penalty applies by expanding the group of vulnerable people to whom it relates to include a person with a substance abuse disorder, a serious mental or chronic physical illness or disability, a developmental disability, a learning disability, or certain educational deficiencies.

The bill prohibits patient brokering activities specifically related to treatment from a health care provider, health care facility, or recovery residence, and makes these acts violations of the patient brokering act and of FDUTPA. The bill amends the patient brokering act to expressly include recovery residences.

The bill creates another civil penalty of not more than $15,000 for a "provider" or "operator" who willfully violates the bill's unethical marketing practices or patient brokering provisions by successfully victimizing, or attempting victimize, a person with a substance abuse disorder, a serious mental or chronic physical illness or disability, a developmental disability, a learning disability, or an educational deficiency affecting the person's ability to contract.

Section 397.501, F.S., contains a list of statutory rights for individuals receiving substance abuse services, including rights to dignity, non-discriminatory services, quality services, confidentiality, counsel and habeas corpus. Service personnel who violate these rights, are liable for damages (unless acting in good faith, reasonably, and without negligence).

The bill amends s. 397.501, F.S., to add a right to a safe living environment for people in residential treatment facilities and recovery residences to the current statutory rights for people receiving substance abuse services.

The bill has an indeterminate negative fiscal impact on the court system.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Recovery Residences

There is no universally accepted definition of "recovery residence" (also known as "sober home" or "sober living home"). Commonly, recovery residences:

- Are alcohol- and drug-free living environments for individuals in recovery who are attempting to maintain abstinence from alcohol and drugs;
- Offer no formal treatment but perhaps mandate or strongly encourage attendance at 12-step groups; and
- Are self-funded through resident fees, and residents may reside there as long as they are in compliance with the residence's rules.[1]

Section 397.311, F.S., defines a recovery residence as a residential dwelling unit, or other form of group housing, that is offered or advertised through any means, including oral, written, electronic, or printed means, by any person or entity as a residence that provides a peer-supported, alcohol-free, and drug-free living environment. The exact number of recovery residences in Florida is currently unknown.[2]

Multiple studies have found that individuals benefit in their recovery by residing in a recovery residence. For example, an Illinois study found regarding those residing in an Oxford House, a very specific type of recovery residence, that:

> [T]hose in the Oxford Houses had significantly lower substance use (31.3% vs. 64.8%), significantly higher monthly income ($989.40 vs. $440.00), and significantly lower incarceration rates (3% vs. 9%). Oxford House participants, by month 24, earned roughly $550 more per month than participants in the usual-care group. In a single year, the income difference for the entire Oxford House sample corresponds to approximately $494,000 in additional production. In 2002, the state of Illinois spent an average of $23,812 per year to incarcerate each drug offender. The lower rate of incarceration among Oxford House versus usual-care participants at 24 months (3% vs. 9%) corresponds to an annual saving of roughly $119,000 for Illinois. Together, the productivity and incarceration benefits yield an estimated $613,000 in savings per year, or an average of $8,173 per Oxford House member.[3]

A cost-benefit analysis regarding residing in Oxford Houses (OH) found variation in cost and benefits, compared to other residences.

> While treatment costs were roughly $3,000 higher for the OH group, benefits differed substantially between groups. Relative to usual care, OH enrollees exhibited a mean net benefit of $29,022 per person. The result suggests that the additional costs associated with OH treatment, roughly $3000, are returned nearly tenfold in the form of

[1] *A Clean and Sober Place to Live: Philosophy, Structure, and Purported Therapeutic Factors in Sober Living Houses,* J Psychoactive Drugs, Jun 2008; 40(2): 153–159, Douglas L. Polcin, Ed.D., MFT and Diane Henderson, B.A.
[2] *Recovery Residence Report*, Department of Children and Families, Office of Substance Abuse and Mental Health, October 1, 2013, available at http://www.myflfamilies.com/service-programs/substance-abuse/publications (last viewed Feb. 7, 2016). The total number is currently unknown, given that the operation of a recovery residence is not under the purview of a mandatory regulatory program.
[3] L. Jason, B. Olson, J., Ferrari, and A. Lo Sasso, *Communal Housing Settings Enhance Substance Abuse Recovery,* 96 American Journal of Public Health (10), (2006), at 1727-1729.

> reduced criminal activity, incarceration, and drug and alcohol use as well as increases in earning from employment... even under the most conservative assumption, we find a statistically significant and economically meaningful net benefit to Oxford House of $17,800 per enrollee over two years.[4]

Additionally, a study in California which focused on recovery residences in Sacramento County and Berkeley found:

- Residents at six months were 16 times more likely to report being abstinent;
- Residents at 12 months were 15 times more likely to report being abstinent; and
- Residents at 18 months were six times more likely to report being abstinent.[5]

In 2013, the Department of Children and Families (DCF) conducted a study of recovery residences in Florida.[6] DCF sought public comment relating to community concern for recovery residences. Three common concerns were the safety of the residents, safety of the neighborhoods and lack of governmental oversight.[7] Participants at public meetings raised the following concerns:

- Residents being evicted with little or no notice;
- Drug testing might be a necessary part of compliance monitoring;
- Unscrupulous landlords, including an alleged sexual offender who was running a woman's program;
- A recovery residence owned by a bar owner and attached to the bar;
- Residents dying in recovery residences;
- Lack of regulation and harm to neighborhoods;
- Whether state agencies have the resources to enforce regulations and adequately regulate these homes;
- Land use problems, and nuisance issues caused by visitors at recovery residences, including issues with trash, noise, fights, petty crimes, substandard maintenance, and parking;
- Mismanagement of resident moneys or medication;
- Treatment providers that will refer people to any recovery residence;
- Lack of security at recovery residences and abuse of residents;
- The need for background checks of recovery residence staff;
- The number of residents living in some recovery residences and the living conditions in these recovery residences;
- Activities going on in recovery residences that require adherence to medical standards and that treatment services may be provided to clients in recovery residences. This included acupuncture and urine tests;
- Houses being advertised as treatment facilities and marketed as the entry point for treatment rather than as a supportive service for individuals who are exiting treatment;
- False advertising;
- Medical tourism;

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[4] A. Lo Sasso, E. Byro, L. Jason, J. Ferrari, and B. Olson, *Benefits and Costs Associated with Mutual-Help Community-Based Recovery Homes: The Oxford House Model*, 35 Evaluation and Program Planning (1), (2012).
[5] D. Polcin, R. Korcha, J. Bond, and G. Galloway, *Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcome,* 38 Journal of Substance Abuse Treatment, 356-365 (2010).
[6] Ch. 2013-040, L.O.F. The 2013-2014 General Appropriations Act directed DCF to determine whether to establish a licensure/registration process for recovery residences and to provide the Governor and Legislature with a report on its findings. In its report, DCF was required to identify the number of recovery residences operating in Florida, identify benefits and concerns in connection with the operation of recovery residences, and the impact of recovery residences on effective treatment of alcoholism and on recovery residence residents and surrounding neighborhoods. DCF was also required to include the feasibility, cost, and consequences of licensing, regulating, registering, or certifying recovery residences and their operators. DCF submitted its report to the Governor and Legislature on October 1, 2013.
[7] *Recovery Residence Report, supra* footnote 4.

- Insurance fraud, through unnecessary medical tests;
- Lack of uniformity in standards; and
- Patient brokering, in violation of Florida Statutes.[8]

Federal Law Applicable to Recovery Residences

Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits discrimination against individuals with disabilities.[9] The ADA requires broad interpretation of the term "disability" so as to include as many individuals as possible under the definition.[10] The ADA defines disability as a physical or mental impairment that substantially limits one or more major life activities.[11] Disability also includes individuals who have a record of such impairment, or are regarded as having such impairment.[12] The phrase "physical or mental impairment" includes, among others[13], drug addiction and alcoholism.[14] However, this only applies to individuals in recovery: ADA protections are not extended to individuals who are actively abusing substances.[15]

Fair Housing Amendment Act

The Fair Housing Amendment Acts of 1988 (FHA) prohibits housing discrimination based upon an individual's handicap.[16] A person is considered to have a handicap if he or she has a physical or mental impairment which substantially limits one or more of his or her major life activities.[17] This includes individuals who have a record of such impairment, or are regarded as having such impairment.[18] Drug and alcohol addictions are considered to be handicaps under the FHA.[19] However, current users of illegal controlled substances and persons convicted for illegal manufacture or distribution of a controlled substance are not considered handicapped under the FHA.

Case Law

An individual in recovery from a drug addiction or alcoholism is protected from discrimination under the ADA and FHA. Based on this protected class status, federal courts have held that mandatory conditions placed on housing for people in recovery from either state or sub-state entities, such as ordinances, licenses or conditional use permits, are overbroad in application and result in violations of

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[8] Id.
[9] 42 U.S.C. s. 12101. This includes prohibition against discrimination in employment, State and local government services, public accommodations, commercial facilities, and transportation. U.S. Department of Justice, *Information and Technical Assistance on the Americans with Disabilities Act*, available at http://www.ada.gov/2010_regs.htm (last visited March 14, 2014).
[10] 42 U.S.C. s. 12102.
[11] Id.
[12] Id.
[13] 28 C.F.R. s. 35.104(4)(1)(B)(ii). The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic) and tuberculosis.
[14] 28 C.F.R. s. 35.104(4)(1)(B)(ii).
[15] 28 C.F.R. s. 35.131.
[16] 42 U.S.C. § 3604. Similar protections are also afforded under the Florida Fair Housing Act, s. 760.23, F.S., which provides that it is unlawful to discriminate in the sale or rental of, or to otherwise make unavailable or deny, a dwelling to any buyer or renter because of a handicap of a person residing in or intending to reside in that dwelling after it is sold, rented, or made available. The statute provides that "discrimination" is defined to include a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford such person equal opportunity to use and enjoy a dwelling.
[17] 42 U.S.C. § 3602(h).
[18] Id.
[19] *Oxford House, Inc. v. Town of Babylon*, 819 F. Supp. 1179, 1182 (E.D.N.Y. 1993).

the FHA and ADA.[20] Additionally, regulations which require registry of housing for protected classes, including recovery residences, have been invalidated by federal courts.[21] Further, federal courts have enjoined state action that is predicated on discriminatory local government decisions.[22]

State and local governments have the authority to enact regulations, including housing restrictions, which serve to protect the health and safety of the community.[23] However, this authority may not be used as a guise to impose additional restrictions on protected classes under the FHA.[24] Further, these regulations must not single out housing for disabled individuals and place requirements which are different and unique from the requirements for housing for the general population.[25] Instead, the FHA and ADA require that a reasonable accommodation be made when necessary to allow a person with a

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[20] *Recovery Residence Report*, *supra* footnote 4. *Jeffrey O. v. City of Boca Raton*, 511 F. Supp. 2d 1339, (Local zoning and density restrictions invalid as discriminatory to individuals in recovery); *Oxford House, Inc. v. Town of Babylon*, 819 F. Supp. 1179 (City singled out plaintiffs for zoning enforcement and inspections on the basis of disability; plaintiff demonstrated city ignored zoning violations by people without disabilities); *Marbrunak v. City of Stow, OH.*, 947 F. 2d 43, (6th Cir. 1992) (Conditional use permit requiring health and safety protections was an onerous burden); *U.S. v. City of Baltimore, MD,* 845 F. Supp. 2d. 640 (D. Md. 2012) (Conditional ordinance was overbroad and discriminatory); *Children's Alliance v. City of Bellevue*, 950 F. Supp. 1491, (W.D. Wash. 1997) (Zoning scheme establishing classes of facilities was overbroad and created an undue burden on a protected class); *Oxford House-Evergreen,* 769 F. Supp. 1329, (Refusal to issue permit was based on opposition of neighbors, not on protection of health and safety as claimed); *Potomac Group Home, Inc.,* 823 F. Supp. 1285, (County requirement for evaluation of program offered at facility at public board, where decisions were based on non-programmatic factors, such as neighbor concerns; requirement to notify neighboring property and enumerated civic organizations violated the FHA).

[21] *Recovery Residence Report, supra* footnote 4. *Nevada Fair Housing Center, Inc., v. Clark County, et. al.,* 565 F. Supp. 2d 1178, (D. Nev. 2008) (Invalidating state statute requiring Nevada State Health Department to operate a registry of group homes); *See, Human Resource Research and Management Group,* 687 F. Supp. 2d 237, (Defendant-city failed to show that registration, inspection and background check requirements were narrowly tailored to support a legitimate government interest); *Community Housing Trust et. al., v. Department of Consumer and Regulatory Affairs et. al.,* 257 F. Supp. 2d 208, (D.C. Cir. 2003) (Zoning administrator's classification of plaintiff-facility to require a certificate of occupancy rose to discriminatory practice under FHA). *See*, e.g., *City of Edmonds v. Oxford House et. al.,* 574 U.S. 725 (1995) (City's restriction on composition of family violated FHAA); *Safe Haven Sober Houses LLC, et. al., v. City of Boston, et. al.,* 517 F. Supp. 2d 557, (D. Mass. 2007); *United States v. City of Chicago Heights*, 161 F. Supp. 2d 819, (N.D. Ill. 2001) (City violated FHA by requiring inspection for protected class housing that was not narrowly tailored to the protection of disabled); *Human Resource Research and Management Group,* 687 F. Supp. 2d 237, (City's purported interest in the number of facilities, in relation to the zoning plan, was not a legitimate government interest; and there was insufficient evidence to justify action by the city in relation to the protection of this class. The city also failed to justify the requirement for a 24 hour staff member, certified by the New York State Office of Alcoholism and Substance Abuse Services).

[22] *Recovery Residence Report, supra* footnote 4. *See e.g., Larkin v. State of Mich.* 883 F. Supp. 172, (E.D. Mich. 1994), judgment aff'd 89 F. 3 d 285, (6th Cir. 1996) (No rational basis for denial of license on the basis of dispersal requirement, and local government's refusal to permit. The Court did find, however, that the city was not a party to the lawsuit because the state statute did not mandate a variance); *Arc of New Jersey, Inc., v. State of N.J.* 950 F. Supp. 637, D.N.J. 1996) (Municipal land use law, including conditional use, spacing and ceiling quotas violated FHA); *North Shore-Chicago Rehabilitation Inc. v. Village of Skokie*, 827 F. Supp. 497, (N.D. Ill. 1993) (Municipalities may not rely on the absence of a state licensing scheme to deny an occupancy permit); *Easter Seal Soc. of New Jersey, Inc. v. Township of North Bergen,* 798 F. Supp. 228 (D.N.J. 1992) (City denial of permit on the basis of failure to obtain state license was due to the city's discriminatory enforcement of zoning enforcement); *Ardmore, Inc. v. City of Akron*, Ohio, 1990 WL 385236 (N.D. Ohio 1990) (Granting a preliminary injunction against the enforcement of an ordinance requiring conditional use permit, even though it was applied to everyone, because Congress intended to protect the rights of disabled individuals to obtain housing).

[23] 42 U.S.C. s. 3604(f)(9).

[24] *Recovery Residence Report, supra* footnote 4. *Bangerter v. Orem City Corp.*, 46 F.3d 1491, (10th Cir. 1995) (Any requirements placed on housing for a protected class based on the protection of the class must be tailored to needs or abilities associated with particular kinds of disabilities, and must have a necessary correlation to the actual abilities of the persons upon whom they are imposed); *Association for Advancement of the Mentally Handicapped, Inc. v. City of Elizabeth,* 876 F. Supp. 614, (D.N.J. 1994) (State and local governments have the authority to protect safety and health, but that authority may not be used to restrict the ability of protected classes to live in the community); *Pulcinella v. Ridley Tp.*, 822 F. Supp. 204,822 F. Supp. 204, (Special conditions may not be imposed under the pretext of health and safety concerns).

[25] *Bangerter v. Orem City Corp.,* 46 F.3d 1491, (10th Cir. 1995) (Invalidating and act and ordinance that facially singles out the handicapped, and applies different and unique rules to them); *Human Resource Research and Management Group, Inc. v. County of Suffolk*, 687 F. Supp. 2d 237 (E.D. N.Y. 2010), ("It is undisputed that [the ordinance] is discriminatory on its face, in that it imposes restrictions and limitations solely upon a class of disabled individuals"); *Potomac Group Home Corp. v. Montgomery County, Md.*, 823 F. Supp. 1285 (No other county law or regulation imposed a similar requirement on a residence occupied by adults without disabilities).

qualifying disability equal opportunity to use and enjoy a dwelling.[26] The governmental entity bears the burden of proving through objective evidence that a regulation serves to protect the health and safety of the community and is not based upon stereotypes or unsubstantiated inferences.[27]

Florida Regulation of Recovery Residences

In Florida, recovery residences are not licensed by the state. Because federal courts interpret state and local licensure requirements for recovery residences as violations of the ADA and FHA, the matter appears to be preempted. Instead, in 2015 Florida enacted sections 397.487-397.4872, F.S., which establish voluntary certification programs for recovery residences and recovery residence administrators, implemented by private credentialing entities. Under the voluntary certification program, DCF approved two credentialing entities to design the certification programs and issue certificates: The Florida Association of Recovery Residences will certify the recovery residences and the Florida Certification Board will certify recovery residence administrators.

Section 397.487, and 397.4871, F.S., set criteria for certification, including a requirement that the certified recovery residences be actively managed by a certified recovery residence administrator. Level 2 background screening is required for all recovery residence owners, directors and chief financial officers, and for administrators seeking certification. Section 397.4872, F.S., allows DCF to exempt an individual from the disqualifying offenses of a Level 2 background screening if the individual meets certain criteria and the recovery residence attests that it is in the best interest of the program.

Under s. 397.487, F.S., the credentialing entities must deny, suspend or revoke certification if a recovery residence or a recovery residence administrator fails to meet and maintain certain criteria. The credentialing entity must inspect recovery residences prior to the initial certification and during every subsequent renewal period, and must automatically terminate certification if it is not renewed within one year of the issuance date.

According to the Florida Association of Recovery Residences, there are 226 certified recovery residences in Florida.[28] Section 397.4872, F.S., requires DCF to publish a list of all certified recovery residences and recovery residences administrators on its website.

While certification is voluntary, Florida law incentivizes certification. Section 397.407, F.S., prohibits licensed substance abuse service providers from referring patients to a recovery residence unless the recovery residence holds a valid certificate of compliance and is actively managed by a certified recovery residence administrator or is owned and operated by a licensed service provider or a licensed service provider's wholly owned subsidiary. This prohibition takes effect July 1, 2016, giving the recovery residences and administrators time to obtain certification.

In addition, ss. 397.487 and 397.4871, F.S., make it a first degree misdemeanor[29] for any entity or person who advertises as a "certified recovery residence" or "certified recovery residence administrator", respectively, unless the entity or person has obtained certification under this section.

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[26] *Recovery Residence Report, supra* footnote 4. 42 U.S.C. s. 3604(f)(3)(B); 42 U.S.C. s. 12131, *et. seq.*, 28 C.F.R. s. 35.130(b)(7). To comply with the reasonable accommodation provisions of the ADA, regulations have been promulgated for public entities (defined by 28 C.F.R. s. 35.104). This includes a self-evaluation plan of current policies and procedures and modify as needed (28 C.F.R. s. 35.105). This is subject to the exclusions of 28 C.F.R. s. 35.150. For interpretation by the judiciary, s*ee, Jeffrey O. v. City of Boca Raton*, 511 F. Supp. 2d 1339 (Local ordinance invalid because city failed to make reasonable accommodations for individuals with disabilities); *Oxford House Inc., v. Township of Cherry Hill*, 799 F. Supp. 450, (D.N.J. 1992) (Reasonable accommodation means changing some rule that is generally applicable to everyone so as to make it less burdensome for a protected class).

[27] *Oconomowoc Residential Programs, Inc., v. City of Milwaukee*, 300 F. 3d 775, (7th Cir. 2002) (Denial for a variance due to purported health and safety concerns for the disabled adults could not be based on blanket stereotypes); *Oxford House- Evergreen v. City of Plainfield,* 769 F. Supp. 1329 (D.N.J. 1991) (Generalized assumptions, subjective fears and speculation are insufficient to prove direct threat to others), *Cason v. Rochester Housing Authority,* 748 F. Supp. 1002, (W.D.N.Y. 1990).

[28] Florida Association of Recovery Residences, Certified Residences, available at http://farronline.org/certification/certified-residences/ (last viewed Feb. 7, 2016).

[29] A first degree misdemeanor is punishable by not more than one year imprisonment and not more than a $1,000 fine. Ss. 775.082, 775.083, F.S.

Florida Deceptive and Unfair Trade Practices Act

The Florida Deceptive and Unfair Trade Practices Act[30] (FDUTPA) makes unlawful unfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce. Violations of FDUTPA are investigated and prosecuted by state attorneys, or the Office of Legal Affairs in the Office of the Attorney General if the violations affect more than one judicial circuit. (s. 501.203, F.S.) Violations maybe remedied by declaratory judgment, injunction, or an action for actual damages; in addition, a court may order sequestration or freezing of assets, receivership, contract amendment, divestment of interests, dissolution or reorganization of any enterprise, or any other legal or equitable relief. (s. 501.207, F.S.) In addition, a court may assess civil penalties of up to $10,000 per violation. (s. 501.2075, F.S.)

FDUTPA imposes larger penalties for willful violations against senior citizens (age 60 or older), persons with disabilities, and military servicemembers and their families. In this context, a person with a disability is one who has a mental or educational impairment that substantially limits one or more major life activities, such as caring for oneself, working, speaking and learning. The civil penalty for a violation of this sort is not more than $15,000.[31]

Courts have defined an "unfair practice" as "one that offends established public policy and one that is immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers."[32] Similarly, courts have define a "deceptive act" as one in which there is a "representation, omission, or practice that is likely to mislead the consumer acting reasonably in the circumstances, to the consumer's detriment."[33]

FDUTPA has been used in cases involving similarly-named companies, which could lead consumers to believe them to be the same[34]; in "bait-and-switch" cases[35]; and instances of unreasonable pricing[36], among many other types of activities.

FDUTPA applies broadly, to any person who engages in this conduct, and would apply to this conduct by substance abuse treatment providers and recovery residences.

Patient Brokering

Florida's patient brokering act, s. 817.505, F.S., (Act) makes it unlawful for any person to engage in patient brokering. Patient brokering is paying to induce, or make a payment in return for, a referral of a patient to or from a health care provider or health care facility. Such payments include commissions, bonuses, rebates, kickbacks, bribes, split-fee arrangements, in cash or in kind, provided directly or indirectly.[37] A violation of the Act is a third degree felony[38], and may also be remedied by an injunction or any other enforcement process. Private entities bringing an action under the Act may recover reasonable expenses, including attorney fees.[39]

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[30] Sections 501.201-501.213, F.S.
[31] Section 501.2077, F.S.
[32] *PNR, Inc. v. Beacon Prop. Mgmt.*, 842 So.2d 773, 777 (Fla.2003) (quoting Samuels v. King Motor Co., 782 So.2d 489, 499 (Fla. 4th DCA 2001)).
[33] Id. at 777 (quoting *Millennium Communs. & Fulfillment, Inc. v. Office of the AG, Dep't of Legal Affairs*, 761 So.2d 1256, 1263 (Fla. 3d DCA 2000)).
[34] *See, e.g., Rain Bird Corp. v. Taylor*, N.D.Fla.2009, 665 F.Supp.2d 1258
[35] *See, e.g., Fendrich v. RBF, L.L.C.*, App. 4 Dist., 842 So.2d 1076 (2003).
[36] *See, e.g., Colomar v. Mercy Hosp., Inc.*, S.D.Fla.2006, 461 F.Supp.2d 1265
[37] Section 817.505(1), F.S.
[38] A third degree felony is punishable by not more than five years of imprisonment and not more than a $5,000 fine. Ss. 775.082, 775.083, F.S.
[39] Section 817.505(4), (6), F.S.

The patient brokering statute applies to any person regulated (or statutorily exempt from regulation by) the Agency for Health Care Administration or the Department of Health, or which has a Medicaid provider contract, or which has a contract with the Department of Children and Families to provide substance abuse or mental health services under part IV of chapter 394. The Act expressly applies to "substance abuse providers" licensed under chapter 397.

The Act also appears to apply to recovery residences. Chapter 397 establishes a voluntary certification program for recovery residences, administered by certification entities chosen by DCF. The certification is not a license; in addition, it is unclear whether a recovery residence is a "substance abuse provider" under the Act because that term is not defined in chapter 397. However, even if a recovery residence is not a health care facility, it is a "person"[40] subject to the Act if the recovery residence participates in a patient brokering arrangement with a substance abuse facility or provider licensed under ch. 397, F.S.

The Act has been used in cases involving split-fee arrangements; for example, an assignment of benefits scenario in which a non-provider suggested a patient go to a particular an MRI facility, paid the facility for the MRI and billed the insurer a greater amount.[41] The Act has also been used in self-referral arrangements; for example, an arrangement by which a series of shell companies, nominee owners and independent contractors were used to conceal relationships that generated a high-volume of Personal Injury Protection patients to a particular provider through a toll-free referral number.[42]

Effect of Proposed Changes

The bill expresses legislative intent to ensure that treatment and recovery support for people who abuse substances is offered and marketed ethically.

Unethical Marketing Practices and Patient Brokering

House Bill 823 creates s. 397.355, F.S., to make certain unethical marketing practices by substance abuse treatment providers and recovery residences unlawful. Specifically, the bill prohibits false or misleading statements by these entities related to their products, goods, services, or location, and prohibits website coding that directs the reader to another website. The bill defines "marketing practices" as all statements made or information disseminated to the public, in any form, which are intended to market or advertise substance abuse treatment or recovery support. The bill makes a violation of this prohibition a violation of FDUTPA. In addition, the bill imposes a civil penalty of not more than $5,000 per willful violation.

The bill amends FDUTPA to expands the circumstances under which the heightened civil penalty ($15,000) may be assessed by expanding the group of vulnerable people for whom it applies. The bill imposes the penalty for people with a "disabling condition" rather than a "disability", and defines "disability" as one who has a substance abuse disorder, a serious mental or chronic physical illness or disability, a developmental disability, a learning disability, or an educational deficiency affecting the person's ability to contract.

The bill prohibits patient brokering activities, using language similar to Florida's patient act and judicial interpretations of the Act. It prohibits soliciting, receiving and making commissions, bonuses, rebates, kickbacks, bribes and split-fee arrangements in return for treatment from a health care provider, health care facility, or recovery residence. The bill makes a violation of this prohibition a violation of the

[40] "Person" is not defined by the Act. Section 1.01(3), F.S., defines "person" as including "individuals, children, firms, associations, joint adventures, partnerships, estates, trusts, business trusts, syndicates, fiduciaries, corporations, and all other groups or combinations". This definition applies in every instance in which "person" is not expressly defined differently.

[41] *Medical Management Group of Orlando, Inc. v. State Farm Mut. Auto. Ins. Co.*, App. 5 Dist., 811 So.2d 705 (2002).

[42] *State Farm Mut. Auto. Ins. Co. v. Physicians Group of Sarasota, L.L.C.*, M.D.Fla.2014, 9 F.Supp.3d 1303 (denying motion to dismiss).

patient brokering act, subject to the same criminal penalties, and of FDUTPA. In addition, the bill imposes a civil penalty of not more than $5,000 per willful violation.

The bill amends the patient brokering act to expressly include recovery residences, and defines the term similarly to the definition in s. 397.311, F.S.

The bill creates another civil penalty of not more than $5,000 for a "provider" or "operator" who willfully violates the bill's unethical marketing practices or patient brokering provisions by successfully victimizing, or attempting victimize, a person with a "disabling condition". Such a person is defined by the bill as one who has a substance abuse disorder, a serious mental or chronic physical illness or disability, a developmental disability, a learning disability, or an educational deficiency affecting the person's ability to contract.

Rights of Individuals Receiving Substance Abuse Services

Section 397.501, F.S., contains a list of statutory rights for individuals receiving substance abuse services, including rights to dignity, non-discriminatory services, quality services, confidentiality, counsel and habeas corpus. Service personnel who violate these rights, are liable for damages (unless acting in good faith, reasonably, and without negligence).

The bill amends s. 397.501, F.S., to add a right to a safe living environment for people in residential treatment facilities and recovery residences. A safe living environment is one without drugs, alcohol, harassment, abuse and harm.

Finally, the bill conforms cross-references in ss. 212.055, 397.416 and 440.102, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 397.305, F.S., relating to legislative findings, intent, and purpose.
Section 2: Amends s. 397.311, F.S., relating to definitions.
Section 3: Creates s. 397.335, F.S., relating to prohibition of unethical marketing practices.
Section 4: Amends s. 397.501, F.S., relating to rights of individuals.
Section 5: Amends s. 501.2077, F.S., relating to violations involving senior citizen, person who has a disability, military servicemember, or the spouse or dependent child of a military servicemember; civil penalties; presumption.
Section 6: Amends s. 817.505, F.S., relating to patient brokering prohibited; exceptions; penalties.
Section 7: Amends s. 212.055, F.S., relating to discretionary sales surtaxes; legislative intent; authorization and use of proceeds.
Section 8: Amends s. 397.416, F.S., relating to substance abuse treatment services; qualified professional.
Section 9: Amends s. 440.102 F.S., relating to drug-free workplace program requirements.
Section 10: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Florida courts may experience and indeterminate increase in caseload if state attorneys prosecute additional cases under FDUTPA or the patient brokering act based on the bill's amendments to

those laws, or if there is an increase in private causes of action under those laws or based on the bill's new right to a safe living environment.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Substance abuse providers and recovery residences which violate the bill's new prohibitions on patient brokering and unethical marketing practices, or who violate the bill's new right to a safe living environment may be subject to civil penalties or private causes of action for damages.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill creates new prohibitions against patient brokering related to treatment from a "health care provider", or a "health care facility", but does not define these terms. Violations are subject to criminal penalties.

The bill requires civil penalties collected for violations of prohibited marketing practices under s. 397.335, F.S., to be deposited in the Substance Abuse Impairment Provider Licensing Trust Fund. This trust fund no longer exists in Florida Statutes.[43] Licensure fees and administrative penalties collected under ss. 397.407 and 397.415, F.S., are currently deposited in the Operations and Maintenance Trust Fund within DCF.[44]

The bill prohibits patient brokering activities specifically related to treatment from a health care provider, health care facility, or recovery residence, and makes these acts violations of the patient brokering act and of FDUTPA. The bill additionally amends the patient brokering act to expressly include recovery

[43] Department of Children and Families, 2016 Legislative Bill Analysis for HB 823, Dec. 10, 2015, on file with the Health and Human Services Committee.
[44] Id.

residences. In doing so the bill prohibits recovery residence to recovery residence referrals. This prohibition may result in legal challenges under the ADA.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to ethical marketing practices for substance abuse services; amending s. 397.305, F.S.; providing legislative intent; amending s. 397.311, F.S.; providing definitions; creating s. 397.335, F.S.; prohibiting substance abuse treatment providers and operators of recovery residences from engaging in certain marketing practices; providing criminal and civil penalties for engaging in such practices; providing for the deposit of civil penalties into a certain trust fund; amending s. 397.501, F.S.; providing a right to a safe living environment for certain individuals; amending s. 501.2077, F.S.; defining the term "disabling condition"; revising definitions; amending s. 817.505, F.S.; adding recovery residences as entities prohibited from patient brokering; defining the term "recovery residence"; amending ss. 212.055, 397.416, and 440.102, F.S.; conforming cross-references; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (10) is added to section 397.305, Florida Statutes, to read:

397.305 Legislative findings, intent, and purpose.—

(10) It is the intent of the Legislature to ensure that treatment and recovery support for individuals who are impaired by substance abuse are offered in an ethical and professional manner that includes the use of ethical marketing practices to ensure the protection of this vulnerable population.

Section 2. Subsections (12) through (20) of section 397.311, Florida Statutes, are renumbered as subsections (13) through (21), respectively, present subsection (21) is renumbered as subsection (23), present subsection (23) is renumbered as subsection (26), present subsection (24) is renumbered as subsection (25), present subsections (25) through (45) are renumbered as subsections (27) through (47), respectively, and new subsections (12) and (24) are added to that section, to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(12) "Disabling condition" means:

(a) A diagnosable substance abuse disorder, serious mental illness, developmental disability, specific learning disability, or chronic physical illness or disability, or the co-occurrence of two or more of these conditions.

(b) An educational deficiency that substantially affects a person's ability to read and comprehend the terms of a contractual agreement to which he or she is a party.

(24) "Marketing practices" includes all statements made or information disseminated to the public, whether oral, written,

printed, or otherwise, which are intended to market or advertise substance abuse treatment services or recovery support.

Section 3. Section 397.335, Florida Statutes, is created to read:

397.335 Prohibition of unethical marketing practices.—The Legislature recognizes that individuals with substance abuse disorders have disabling conditions that make them vulnerable to fraudulent marketing practices. To protect the health, safety, and welfare of the general public and this vulnerable population, substance abuse treatment providers and operators of recovery residences may not engage in the following marketing practices:

(1) Making false or misleading statements or providing false or misleading information about their products, goods, services, or geographical location in marketing or advertising materials or media or on their respective websites.

(2) Including on their respective websites coding that provides false information or surreptitiously directs the reader to another website.

(3) Soliciting, receiving, or making an attempt to solicit or receive a commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engaging or making an attempt to engage in a split-fee arrangement in return for an acceptance or acknowledgment of treatment from a health care provider, health care facility, or recovery residence. A violation of this subsection is a violation of the prohibition

on patient brokering and is subject to criminal penalties under s. 817.505.

A violation of this section is a violation of the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501 and is subject to a civil penalty of not more than $5,000 for each willful violation. A provider or operator who willfully uses, or has willfully used, a method, act, or practice in violation of this section which victimizes or attempts to victimize a person with a disabling condition is liable for a civil penalty of not more than $15,000 for each violation if the provider or operator knew or should have known that such conduct was unfair or deceptive. Civil penalties collected under this section must be deposited in the Substance Abuse Impairment Provider Licensing Trust Fund.

Section 4. Subsections (9) and (10) of section 397.501, Florida Statutes, are renumbered as subsections (10) and (11), respectively, and a new subsection (9) is added to that section, to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(9) RIGHT TO SAFE LIVING ENVIRONMENT.—Each individual receiving treatment services in a residential treatment facility

or living in a recovery residence has the right to a safe living environment free from drugs, alcohol, harassment, abuse, and harm.

Section 5. Section 501.2077, Florida Statutes, is amended to read:

501.2077 Violations involving senior citizen, person who has a disabling condition ~~disability~~, military servicemember, or the spouse or dependent child of a military servicemember; civil penalties; presumption.—

(1) As used in this section, the term:

(a) "Disabling condition" means:

1. A diagnosable substance abuse disorder, serious mental illness, developmental disability, specific learning disability, or chronic physical illness or disability, or the co-occurrence of two or more of these conditions.

2. An educational deficiency that substantially affects a person's ability to read and comprehend the terms of a contractual agreement to which he or she is a party.

(b) "Major life activities" means functions associated with the normal activities of independent daily living, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

~~(b) "Mental or educational impairment" means:~~

~~1. A mental or psychological disorder or specific learning disability.~~

~~2. An educational deficiency that substantially affects a~~

~~person's ability to read and comprehend the terms of any contractual agreement entered into.~~

(c) "Military servicemember" means a person who is on active duty in, or a veteran of, the United States Armed Forces.

1. "Active duty" has the same meaning as provided in s. 250.01.

2. "Veteran" has the same meaning as provided in s. 1.01.

(d) "Person who has a disabling condition ~~disability~~" means a person who has a mental or educational impairment that substantially limits one or more major life activities.

(e) "Senior citizen" means a person who is 60 years of age or older.

(2) A person who is willfully using, or has willfully used, a method, act, or practice in violation of this part which victimizes or attempts to victimize a senior citizen or a person who has a disabling condition ~~disability~~ is liable for a civil penalty of not more than $15,000 for each such violation if she or he knew or should have known that her or his conduct was unfair or deceptive.

(3) A person who is willfully using, or has willfully used, a method, act, or practice in violation of this part directed at a military servicemember or the spouse or dependent child of a military servicemember is liable for a civil penalty of not more than $15,000 for each such violation if she or he knew or should have known that her or his conduct was unfair or deceptive.

(4) An order of restitution or reimbursement based on a violation of this part committed against a senior citizen, a person who has a disabling condition ~~disability~~, a military servicemember, or the spouse or dependent child of a military servicemember has priority over the imposition of civil penalties for such violations pursuant to this section.

(5) Civil penalties collected pursuant to this section shall be deposited into the Legal Affairs Revolving Trust Fund of the Department of Legal Affairs and allocated solely to the Department of Legal Affairs for the purpose of preparing and distributing consumer education materials, programs, and seminars to benefit senior citizens, persons who have a disabling condition ~~disability~~, and military servicemembers or to further enforcement efforts.

Section 6. Subsection (1) of section 817.505, Florida Statutes, is amended, and paragraph (d) is added to subsection (2) of that section, to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(1) It is unlawful for any person, including any health care provider, ~~or~~ health care facility, or recovery residence, to:

(a) Offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage to or from a health care

provider, ~~or~~ health care facility, or recovery residence;

(b) Solicit or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring patients or patronage to or from a health care provider, ~~or~~ health care facility, or recovery residence;

(c) Solicit or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for the acceptance or acknowledgment of treatment from a health care provider, ~~or~~ health care facility, or recovery residence; or

(d) Aid, abet, advise, or otherwise participate in the conduct prohibited under paragraph (a), paragraph (b), or paragraph (c).

(2) For the purposes of this section, the term:

(d) "Recovery residence" means a residential dwelling unit or other form of group housing which is offered or advertised by a person or entity through any form of communication, including oral, written, electronic, or print media, as a residence that provides a peer-supported, alcohol-free, and drug-free living environment.

Section 7. Paragraph (e) of subsection (5) of section 212.055, Florida Statutes, is amended to read:

212.055 Discretionary sales surtaxes; legislative intent;

authorization and use of proceeds.—It is the legislative intent that any authorization for imposition of a discretionary sales surtax shall be published in the Florida Statutes as a subsection of this section, irrespective of the duration of the levy. Each enactment shall specify the types of counties authorized to levy; the rate or rates which may be imposed; the maximum length of time the surtax may be imposed, if any; the procedure which must be followed to secure voter approval, if required; the purpose for which the proceeds may be expended; and such other requirements as the Legislature may provide. Taxable transactions and administrative procedures shall be as provided in s. 212.054.

(5) COUNTY PUBLIC HOSPITAL SURTAX.—Any county as defined in s. 125.011(1) may levy the surtax authorized in this subsection pursuant to an ordinance either approved by extraordinary vote of the county commission or conditioned to take effect only upon approval by a majority vote of the electors of the county voting in a referendum. In a county as defined in s. 125.011(1), for the purposes of this subsection, "county public general hospital" means a general hospital as defined in s. 395.002 which is owned, operated, maintained, or governed by the county or its agency, authority, or public health trust.

(e) A governing board, agency, or authority shall be chartered by the county commission upon this act becoming law. The governing board, agency, or authority shall adopt and

implement a health care plan for indigent health care services. The governing board, agency, or authority shall consist of no more than seven and no fewer than five members appointed by the county commission. The members of the governing board, agency, or authority shall be at least 18 years of age and residents of the county. No member may be employed by or affiliated with a health care provider or the public health trust, agency, or authority responsible for the county public general hospital. The following community organizations shall each appoint a representative to a nominating committee: the South Florida Hospital and Healthcare Association, the Miami-Dade County Public Health Trust, the Dade County Medical Association, the Miami-Dade County Homeless Trust, and the Mayor of Miami-Dade County. This committee shall nominate between 10 and 14 county citizens for the governing board, agency, or authority. The slate shall be presented to the county commission and the county commission shall confirm the top five to seven nominees, depending on the size of the governing board. Until such time as the governing board, agency, or authority is created, the funds provided for in subparagraph (d)2. shall be placed in a restricted account set aside from other county funds and not disbursed by the county for any other purpose.

1. The plan shall divide the county into a minimum of four and maximum of six service areas, with no more than one participant hospital per service area. The county public general hospital shall be designated as the provider for one of the

service areas. Services shall be provided through participants' primary acute care facilities.

2. The plan and subsequent amendments to it shall fund a defined range of health care services for both indigent persons and the medically poor, including primary care, preventive care, hospital emergency room care, and hospital care necessary to stabilize the patient. For the purposes of this section, "stabilization" means stabilization as defined in s. 397.311(43) ~~s. 397.311(41)~~. Where consistent with these objectives, the plan may include services rendered by physicians, clinics, community hospitals, and alternative delivery sites, as well as at least one regional referral hospital per service area. The plan shall provide that agreements negotiated between the governing board, agency, or authority and providers shall recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care to draw down federal funds where appropriate, and require cost containment, including, but not limited to, case management. From the funds specified in subparagraphs (d)1. and 2. for indigent health care services, service providers shall receive reimbursement at a Medicaid rate to be determined by the governing board, agency, or authority created pursuant to this paragraph for the initial emergency room visit, and a per-member per-month fee or capitation for those members enrolled in their service area, as compensation for the services rendered following the initial emergency visit. Except for provisions of

emergency services, upon determination of eligibility, enrollment shall be deemed to have occurred at the time services were rendered. The provisions for specific reimbursement of emergency services shall be repealed on July 1, 2001, unless otherwise reenacted by the Legislature. The capitation amount or rate shall be determined prior to program implementation by an independent actuarial consultant. ~~In no event shall such~~ Reimbursement rates may not exceed the Medicaid rate. The plan must also provide that any hospitals owned and operated by government entities on or after the effective date of this act must, as a condition of receiving funds under this subsection, afford public access equal to that provided under s. 286.011 as to any meeting of the governing board, agency, or authority the subject of which is budgeting resources for the retention of charity care, as that term is defined in the rules of the Agency for Health Care Administration. The plan shall also include innovative health care programs that provide cost-effective alternatives to traditional methods of service and delivery funding.

3. The plan's benefits shall be made available to all county residents currently eligible to receive health care services as indigents or medically poor as defined in paragraph (4)(d).

4. Eligible residents who participate in the health care plan shall receive coverage for a period of 12 months or the period extending from the time of enrollment to the end of the

current fiscal year, per enrollment period, whichever is less.

5. At the end of each fiscal year, the governing board, agency, or authority shall prepare an audit that reviews the budget of the plan, delivery of services, and quality of services~~,~~ and makes recommendations to increase the plan's efficiency. The audit shall take into account participant hospital satisfaction with the plan and assess the amount of poststabilization patient transfers requested, and accepted or denied, by the county public general hospital.

Section 8. Section 397.416, Florida Statutes, is amended to read:

397.416 Substance abuse treatment services; qualified professional.—Notwithstanding any other provision of law, a person who was certified through a certification process recognized by the former Department of Health and Rehabilitative Services before January 1, 1995, may perform the duties of a qualified professional with respect to substance abuse treatment services as defined in this chapter, and need not meet the certification requirements contained in s. 397.311(32) ~~s. 397.311(30)~~.

Section 9. Paragraphs (d) and (g) of subsection (1) of section 440.102, Florida Statutes, are amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(1) DEFINITIONS.—Except where the context otherwise requires, as used in this act:

(d) "Drug rehabilitation program" means a service provider, established pursuant to s. 397.311(41) ~~s. 397.311(39)~~, that provides confidential, timely, and expert identification, assessment, and resolution of employee drug abuse.

(g) "Employee assistance program" means an established program capable of providing expert assessment of employee personal concerns; confidential and timely identification services with regard to employee drug abuse; referrals of employees for appropriate diagnosis, treatment, and assistance; and followup services for employees who participate in the program or require monitoring after returning to work. If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by service providers pursuant to s. 397.311(41) ~~s. 397.311(39)~~.

Section 10. This act shall take effect July 1, 2016.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Hager offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 16.619, Florida Statutes, is created to read:

16.619 Substance Abuse and Recovery Fraudulent Business Practices Pilot Program.—

(1)LEGISLATIVE FINDINGS. The Legislature finds that there is a need to develop and implement a local pilot program to coordinate state and local agencies, law enforcement entities, and investigative units in order to increase the effectiveness of programs and initiatives dealing with the regulation, prevention, detection, and prosecution of unethical and

fraudulent business practices within the substance abuse industry.

(2) ESTABLISHMENT. The Substance Abuse and Recovery Fraudulent Business Practices Pilot Program is created within the office of the State Attorney for the 15th Judicial Circuit to coordinate and further state and local efforts to address unscrupulous entities who use unethical and fraudulent business practices to prey on vulnerable individuals with substance use disorders and their families. The pilot project shall involve identifying and implementing those strategies possible within current resources and existing law to address fraudulent business and unethical marketing practices in the provision of substance abuse services. The State Attorney for the 15th Circuit may end the pilot project after its work has been completed.

(3) MEMBERSHIP. The pilot program shall be developed by the State Attorney for the 15th Judicial Circuit, in consultation with an advisory panel chaired by the State Attorney for the 15th Judicial Circuit. The advisory panel shall include at a minimum the following 9 members, appointed by and serving at the pleasure of the State Attorney for the 15th Judicial Circuit unless otherwise specified:

(a) A representative of the Department of Children and Families, appointed by the secretary of the department.

(b) The Sheriff of Palm Beach County or designee.

(c) A representative from the local business organizations.

(d) A representative from the health insurance industry.

(e) A representative from the substance abuse treatment industry.

(f) The Executive Director or designee of the Florida Association of Recovery Residences.

(g) The Executive Director or designee of the Florida Alcohol and Drug Abuse Association.

(h) A county official.

(i) An official representing local cities.

(4) TERMS OF MEMBERSHIP; COMPENSATION.

(a) The State Attorney of the 15th Judicial Circuit shall call meetings of the advisory panel as necessary to guide the pilot project.

(b) The Legislature finds that the advisory panel serves a legitimate state, county, and municipal purpose and that service on the advisory panel is consistent with a member's principal service in a public office or employment. Therefore membership on the strike force does not disqualify a member from holding any other public office or from being employed by a public entity, except that a member of the Legislature may not serve on the advisory panel.

(c) Members of the strike force shall serve without compensation.

(5) DUTIES. In developing and implementing the pilot project, the State Attorney of the 15th Judicial Circuit, in collaboration with the advisory panel, shall:

(a) Identify the types of fraudulent business and unethical marketing practices engaged in by providers of substance abuse services and recovery residences;

(b) Collect and organize data concerning the marketing and business practices that are unethical or fraudulent by the substance abuse treatment industry and recovery residences;

(c) Conduct a census of local, state, and federal efforts to address patient brokering, unfair and deceptive trade practices in this state, including fraud detection, prevention, and prosecution, in order to discern overlapping missions, maximize existing resources, and strengthen current programs.

(d) Review the adequacy of laws addressing such practices;

(e) Develop a range of strategies to address these practices and evaluate their effectiveness and cost;

(f) Plan for and implement in collaboration with relevant entities such strategies as are possible within current resources and existing law. Such strategies may include but are not limited to communication with providers about practices that are fraudulent, communication to individuals and families about fraudulent practices they may be subject to, increased enforcement through the Department of Children and Families' current regulatory authority, a local warm line for receiving information about fraudulent practices, and better coordination of state and local resources for enforcement.

(g) Recommend to the Department of Children and Families and the Legislature revisions to law and state agency practices that may enhance the effectiveness of state and local efforts.

(7) REPORTS. While the pilot project is in development or being implemented, the State Attorney of the 15th Judicial Circuit shall annually submit a report on the pilot project by October 1 to the Governor, President of the Senate, and the Speaker of the House of Representatives.

Section 2. This act shall take effect upon becoming a law.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert: An act relating to Substance Abuse and Recovery Fraudulent Business Practices Pilot Program; creating s. 16.619, F.S.; providing legislative findings; establishing the Substance Abuse and Recovery Fraudulent Business Practices Pilot Program within the office of the State Attorney of the 15th Circuit; providing membership; establishing duties; requiring reports; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1083 Agency for Persons with Disabilities
SPONSOR(S): Renner
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	10 Y, 0 N	Brazzell	Brazzell
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Fontaine	Pridgeon
3) Health & Human Services Committee		Brazzell	Calamas

SUMMARY ANALYSIS

Individuals with specified developmental disabilities who meet Medicaid eligibility requirements may receive services in the community through the state's Medicaid Home and Community-Based Services (HCBS) waiver (known as iBudget Florida), or in an institutional setting known as an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

Currently, due to demand exceeding available funding, individuals with developmental disabilities who wish to receive iBudget Florida HCBS services administered by the Agency for Persons with Disabilities (APD) are placed on a wait list for services in priority categories of need, unless they are in a crisis. As of November 1, 2015, 21,459 individuals were waiting for developmental disability waiver services.

HB 1083 amends s. 393.065(5), F.S., to make permanent the FY 2015-16 implementing bill's temporary changes related to the waiver waiting list prioritization categories. The bill allows individuals with developmental disabilities needing both waiver and extended foster care child welfare services to be prioritized in Category 2 and, when enrolled on the waiver, to be served by both APD and community-based care organizations. The bill delineates responsibilities of the different entities providing services. Second, the bill permits waiver enrollment without first being placed on the waiting list for individuals who were on an HCBS waiver in another state and whose parent or guardian is an active-duty military servicemember transferred into the state. Third, the bill provides that individuals remaining on the waiting list after other individuals are added are not substantially affected by agency action and not entitled to a hearing under s. 393.125, F.S., or administrative proceeding under chapter 120, F.S.

HB 1083 permits waiver enrollees to receive increases in their allotted funding for services if they have a significant need for transportation to waiver-funded adult day training or employment services and have no other reasonable transportation options.

The bill requires contracted providers of waiver services to:

- Use any APD data management systems to document service provision to APD clients and to have required hardware and software for doing so.
- Comply with requirements established by APD for provider staff training and professional development.
- Cooperate with requests for information, documentation, and inspection involved in utilization reviews, if the provider is an ICF/DD.

HB 1083 also adds Down syndrome to the definition of "developmental disability." Such individuals already are eligible for HCBS waiver services under that diagnosis and also may qualify for services due to intellectual disability.

The bill does not appear to have a fiscal impact on state or local government. See fiscal comments.

The bill provides for an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Agency for Persons with Disabilities

The Agency for Persons with Disabilities (APD) provides services to persons with developmental disabilities. A developmental disability is defined as a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.[1]

While Down syndrome is not among the disabilities included in the definition of "developmental disability", it is specifically included as a qualifying disability for eligibility for Home and Community-Based (HCBS) waiver services provided by APD.[2] Down syndrome is a chromosomal condition that is associated with intellectual disability, a characteristic facial appearance, and weak muscle tone (hypotonia) in infancy. All affected individuals experience cognitive delays and so may qualify for APD services due to their intellectual disability (though the intellectual disability is usually mild to moderate).[3] Individuals with a primary diagnosis of Down syndrome comprise about 1% of APD's clients.[4]

The HCBS waiver, known as iBudget Florida, offers 27 supports and services delivered by contracted service providers to assist individuals to live in their community. Examples of waiver services enabling children and adults to live in their own home, a family home, or in a licensed residential setting are residential habilitation, behavioral services, companion, adult day training, employment services, and physical therapy.[5]

While the majority of individuals served by APD live in the community, a small number live and receive services in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). ICF/DD's are defined in s. 393.063(22), F.S., as residential facilities licensed and certified by the Agency for Health Care Administration (AHCA) pursuant to part VIII of ch. 400. ICF/DD's are considered institutional placements.

Home- and Community-Based Services Waiver (iBudget Florida)

APD administers iBudget Florida pursuant to s. 393.0662, F.S. iBudget Florida uses an algorithm, or formula, to set individuals' funding allocations for waiver services. The statute authorizes APD to give individuals additional funding under certain conditions (such as a temporary or permanent change in need, or an extraordinary need that the algorithm does not address).[6] APD phased in the

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[1] S. 393.063(9), F.S.

[2] S. 393.0662(1) , F.S., provides eligibility for individuals with a diagnosis of Down syndrome.

[3] Rule 65G-4.014, F.A.C. requires that qualifying under an intellectual disability diagnosis requires "significantly subaverage general intellectual functioning evidenced by an Intelligence Quotient (IQ) two or more standard deviations below the mean on an individually administered standardized intelligence test, and significant deficits in adaptive functioning in one or more" domains such as communication skills, self-care and home living.

[4] *Overview of the Agency for Persons with Disabilities*, presentation at the House Children, Families, and Seniors Subcommittee, Jan. 7, 2015.

[5] Agency for Persons with Disabilities, Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2015-16, November 2015.

[6] S. 393.0662(1)(b), F.S.

implementation of iBudget Florida, with the final areas transitioned from the previous tiered waiver system on July 1, 2013.[7]

However, the iBudget Florida program has been the subject of litigation. In September 2014, after a 1st District Court of Appeal ruling regarding the program's rules, APD reset approximately 14,000 individuals' budget allocations to higher amounts.[8] APD began rulemaking to adopt new rules to replace the previous ones.[9] APD, in collaboration with stakeholders, developed a revised algorithm. APD has filed to adopt rules including this revised algorithm and related funding calculation methods.[10]

iBudget statutes were amended by the FY 2015-16 General Appropriations Act implementing bill to permit additional funding beyond that allocated by the algorithm for transportation to a waiver-funded adult day training program or to employment under certain conditions.[11]

Waiver Enrollment Prioritization

As of December 14, 2015, 31,665 individuals were enrolled on the iBudget Florida waiver.[12] The majority of waiver enrollees live in a family home with a parent, relative, or guardian.

The Legislature appropriated $994,793,906 for Fiscal Year 2015-2016 to provide services through the HCBS waiver program, including federal match of $601,153,957.[13] However, this funding is insufficient to serve all persons desiring waiver services. To enable APD to remain within legislative appropriations, waiver enrollment is limited. Accordingly, APD maintains a wait list for waiver services. Prioritization for the wait list is provided in s. 393.065(5), F.S., and also in the FY 15-16 implementing bill.[14]

As part of the wait list prioritization process, clients are assigned to one of seven categories. The underlying statute prioritizes need as follows:

- Category 1 – Clients deemed to be in crisis.
- Category 2 – Children from the child welfare system with an open case in the Department of Children and Families' statewide child welfare information system.
- Category 3 – Includes, but is not limited to, clients:
    - Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;
    - Who are at substantial risk of incarceration or court commitment without supports;
    - Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or
    - Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.
- Category 4 – Includes, but is not limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available;
- Category 5 – Includes, but is not limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive

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[7] *Supra,* note 5.
[8] Agency for Persons with Disabilities, iBudget Florida, http://apd.myflorida.com/ibudget/ (last visited December 15, 2015).
[9] Department of State, Florida Administrative Register, Vol. 40, No. 207, Oct. 23, 2014, pg. 4703-4706.
[10] These rules have been challenged as well. *G. B.; Z. L., through his guardian K. L.; J. H.; and M. R. v. the Agency for Persons with Disabilities*, Case No. 15-005803RP (Fla. DOAH).
[11] S. 21, Ch. 2015-222, Laws of Florida.
[12] E-mail from Caleb Hawkes, Deputy Legislative Affairs Director, Agency for Persons with Disabilities. RE: Requested information for bill analysis for APD agency bill (Dec. 14, 2015). On file with Children, Families and Seniors Subcommittee.
[13] Line 251, Ch. 2015-221, Laws of Florida.
[14] S. 20, Ch. 2015-222, Laws of Florida

employment, or to pursue an accredited program of postsecondary education to which they have been accepted.
- Category 6 – Clients 21 years of age or older who do not meet the criteria for categories 1-5.
- Category 7 – Clients younger than 21 years of age who do not meet the criteria for categories 1-4.[15]

As of November 1, 2015, there were 21,459 people on the wait list for HCBS waiver program services. A majority of people on the wait list have been on the list for more than 5 years, though some are children receiving services through the school system and others are individuals who have been offered waiver services previously but refused them and chose to remain on the wait list.[16]

APD HCBS Length of Wait		
Length of Wait	#	%
1 year or less	1,886	8.8
1+ to 2 years	1,534	7.1
2+ to 3 years	1,229	5.7
3+ to 4 years	1,460	6.8
4+ to 5 years	1,522	7.1
5+ to 6 years	1,617	7.5
6+ to 7 years	1,709	8.0
7+ to 8 years	1,634	7.6
8+ to 9 years	1,774	8.3
9+ to 10 years	1,797	8.4
10+ years	5,297	24.7

For several years, while APD experienced significant deficits, APD was limited to newly enrolling on the waiver only individuals determined to be in crisis. Only since FY 2013-14, when APD has remained within budget, has the Legislature provided funding to APD to serve individuals from the wait list who were not in crisis but had a high priority for service needs. Since July 1, 2013, APD has enrolled 2,392 such individuals[17].

The statutory wait list prioritization has been changed in the past two legislative sessions via the implementing bill. The FY 2014-15 implementing bill allowed individuals who are receiving home and community-based waiver services in other states to be enrolled immediately on the waiver if their parent or guardian is on active military duty and transfers to Florida.[18] The FY 2015-16 implementing bill also allowed immediate waiver enrollment for servicemembers' dependents previously on a waiver. Since July 1, 2014, 10 such individuals have enrolled on the waiver.[19]

The FY 2014-15 implementing bill limited the individuals in Category 2 to children with an open case in the child welfare system who were at the time of finalization of an adoption with placement in a family home, reunification with family members with placement in a family home, or permanent placement with a relative in a family home. The FY 2015-16 implementing bill maintained the 2014-15 changes but added to Category 2 those youth with developmental disabilities who are in extended foster care to be served by both the waiver and the child welfare system. The FY 2015-16 implementing bill also specified the services that APD and the community-based care lead agencies providing foster care

[15] S. 393.065(5), F.S.
[16] Supra, note 5.
[17] *Id.*
[18] S. 9, Ch. 2014-58, L.O.F.
[19] *Supra*, note 12.

services must provide these enrollees. Since July 1, 2015, 30 individuals in extended foster care have enrolled on the waiver.

Both the FY 2014-15 and 2015-16 implementing bills also specified that:

- After individuals formerly on the waiting list are enrolled on the waiver, those remaining on the waiting list are not substantially affected by agency action and not entitled to a hearing under s. 393.125, F.S., or administrative proceeding under chapter 120, F.S.
- APD must use a prioritization tool for prioritizing individuals for waiver enrollment within categories certain categories.

Client Data Management System

APD must manage data to meet federal requirements for administering the iBudget HCBS waiver, such as tracking, measuring, reporting, and providing quality improvement processes for 32 specific program performance measures. However, APD relies heavily on manual processes and disparate systems to collect, analyze, and report data, which is inefficient and error-prone.

The Legislature appropriated funding in FY 2015-16 for APD to develop a client data management system for verifying service delivery by providers, billing waiver services, and processing claims.[20] This system will also be used for program quality improvement purposes. APD contracted with a vendor to configure a commercial off-the-shelf product to APD business processes, and anticipates providers will need to begin using the system during FY 2016-2017. Providers will need standard software and technology in order to log into the system.[21]

Provider Staff Training and Professional Development

Pursuant to the waiver agreement with the federal government, APD must coordinate, develop, and provide specialized training for providers and their employees to promote health and well-being of individuals served.[22] These requirements are currently in the Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook. For example, the handbook outlines required basic and in-service training and continuing education for direct service providers on topics such as person-centered planning, maintaining health and safety, reporting to the abuse hotline, and first aid. Providers of certain services such as supported employment or supported living must have additional pre-service certification training. Training is typically offered through several modalities, such as the internet, DVD, and live classroom training.[23]

Utilization Review of ICF/DD's

While most individuals served by APD live in the community, a small number live in ICF/DD's. ICF/DD's are defined in s. 393.063(22), F.S., as residential facilities licensed and certified by AHCA pursuant to part VIII of ch. 400. There are approximately 2,866 private and public ICF/DD beds in Florida.[24]

ICF/DD's are considered institutional placements rather than community placements. Accordingly, the federal government requires routine utilization reviews for individuals in ICF/DD's to ensure that they are not inappropriately institutionalized. Utilization reviews must be conducted by a group of professionals referred to as the Utilization Review Committee, which must include at least one physician and one individual knowledgeable in the treatment of intellectual disabilities.

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[20] SB 2500A, line 265.
[21] Agency for Persons with Disabilities, Agency Analysis of 2016 Act Relating to the Agency for Persons with Disabilities.
[22] *Id.*
[23] Rule 59G-13.070, F.A.C. The handbook may be accessed at http://apd.myflorida.com/ibudget/.
[24] *Supra*, note 21.

The Medicaid state plan approved by the federal government states that APD will conduct utilization reviews. APD performs this function through an interagency agreement with AHCA.[25] There is no express statutory requirement or authorization for APD to conduct utilization reviews.

Effect of Proposed Changes

Home and Community-Based Services Waiver

Waiver Enrollment Prioritization

HB 1083 makes permanent the FY 2015-16 implementing bill's temporary changes related to the waiver waiting list prioritization categories. The bill requires APD to prioritize, in Category 2, children in the child welfare system being reunified with their families or being placed permanently with an adoptive family or relatives and youth with developmental disabilities in extended foster care who must be served by both APD and the community-based care (CBC) organizations. The bill also delineates the responsibilities of the different entities providing services to these youth; specifically, APD must provide waiver services, including residential habilitation that supports individuals living in congregate settings, and the CBC lead agency must fund room and board at the prevailing foster care rate as well as provide case management and related services.

The bill permits waiver enrollment without first being placed on the waiting list for individuals who were on an HCBS waiver in another state and whose parent or guardian is an active-duty military servicemember transferred into the state. This means active-duty servicemembers' dependents previously on a waiver are not placed in a waiting list category but are immediately enrolled on the waiver.

The bill also specifies that after individuals formerly on the waiting list are enrolled on the waiver, those remaining on the waiting list are not substantially affected by agency action and not entitled to a hearing under s. 393.125, F.S., or administrative proceeding under chapter 120, F.S.

The bill permits rulemaking to specify tools for prioritizing waiver enrollment within categories.

iBudget Florida Funding

The bill also makes permanent the Fiscal Year 2015-16 appropriations implementing bill language that adds transportation needs to the list of the circumstances that may qualify individuals to receive additional funding beyond that calculated through the algorithm. Specifically, APD may grant a funding increase to individuals whose iBudget allocations are insufficient to pay for transportation services to a waiver-funded adult day training program or employment services and who have no other reasonable transportation options. This would allow such individuals to purchase transportation services to attend adult day programs or access employment services.

Client Data Management System

The bill requires APD service providers to use APD data management systems to document service provision to agency clients. Providers would need to have the hardware and software necessary to use these systems, as established by APD. The bill also requires providers to ensure any staff directly serving clients meet APD requirements for training and professional development.

Utilization Review of Intermediate Care Facilities for the Developmentally Disabled

The bill requires APD to conduct utilization reviews for ICF/DD's and requires ICF/DD's to cooperate with these reviews, including requests for information, documentation, and inspection. This will ensure

[25] *Id.*

that Florida continues to meet federal requirements for conducting utilization reviews pursuant to the approved Medicaid state plan.

Down Syndrome

The bill also adds Down syndrome to the definition of "developmental disability." APD already serves individuals with a diagnosis of Down syndrome due to their statutory eligibility under that diagnosis for HCBS waiver services. Individuals with Down syndrome currently may also qualify for APD services due to the presence of an intellectual disability.[26]

B. SECTION DIRECTORY:

Section 1: Amends s. 393.063, F.S., relating to definitions.
Section 2: Amends s. 393.065, F.S., relating to application and eligibility determination.
Section 3: Amends s. 393.066, F.S., relating to community services and treatment.
Section 4: Amends s. 393.0662, F.S., relating to individual budgets for delivery of home and community-based services; iBudget system established.
Section 5: Creates s. 393.0679, F.S., relating to utilization review.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The fiscal impact on the private sector is indeterminate. APD will have to establish requirements for training and career development of direct care provider staff and for hardware and software required for providers to use the new APD client data management system. If APD chooses to maintain the training and career development provisions that are presently required by the waiver program and requires hardware and software currently possessed by providers, the bill will have no direct economic impact on providers. It is unknown what training and career development requirements or hardware and software requirements APD will establish, or the extent to which providers will have to acquire hardware and software to meet those requirements.

[26] Rule 65G-4.014 F.A.C.

D. FISCAL COMMENTS:

The Legislature determines the funding available for HCBS waiver services for individuals with developmental disabilities through the appropriations process. APD then serves individuals previously enrolled on the waiver and newly enrolls additional individuals to the extent that funding permits.

APD is currently administering the waiver program in accordance with the waiver enrollment and iBudget allocation requirements of HB 1083, since those provisions are current law through the FY 2015-16 implementing bill. HB 1083 will make these requirements permanent rather than reverting to the underlying statutory language.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Agency for Persons with Disabilities; amending s. 393.063, F.S.; revising the definition of the term "developmental disability"; amending s. 393.065, F.S.; revising priority classifications for clients on a waiting list for Medicaid home and community-based waiver services; requiring the Agency for Persons with Disabilities to provide waiver services and community-based care lead agencies to provide certain funding and services for specified individuals who need waiver and extended foster care services; requiring an individual to be allowed to receive home and community-based services if his or her parent or guardian is an active-duty servicemember transferred to this state under certain circumstances; providing that individuals remaining on the waiting list are not entitled to a hearing in accordance with federal law or administrative proceeding under state law; amending s. 393.066, F.S.; requiring persons and entities under agency contract to provide community services and treatment to document service delivery using agency data management systems and meet certain technical and training requirements; amending s. 393.0662, F.S.; providing requirements for an increase in iBudget funding allocations for clients needing certain transportation

services; creating s. 393.0679, F.S.; requiring the agency to conduct a utilization review of certain intermediate care facilities for individuals with developmental disabilities; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (9) of section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.—For the purposes of this chapter, the term:

(9) "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

Section 2. Subsection (5) of section 393.065, Florida Statutes, is amended, subsections (6) and (7) are renumbered as subsections (7) and (9), respectively, and amended, and new subsections (6) and (8) are added to that section, to read:

393.065 Application and eligibility determination.—

(5) ~~Except as otherwise directed by law, beginning July 1, 2010,~~ The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule. Clients assigned to this category shall be given first priority to receive waiver services.

(b) Category 2, which includes individuals on the waiting ~~children on the wait~~ list who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years old but not yet 22 years old and who need both waiver services and extended foster care services.

2. At least 18 years old but not yet 22 years old and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years old but not yet 22 years old and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(4) and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services

available through the Medicaid state plan.

(c) Category 3, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available.

(e) Category 5, which includes, but is not required to be limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.

(f) Category 6, which includes clients 21 years of age or older who do not meet the criteria for category 1, category 2, category 3, category 4, or category 5.

(g) Category 7, which includes clients younger than 21 years of age who do not meet the criteria for category 1, category 2, category 3, or category 4.

Within categories 3, 4, 5, 6, and 7, the agency shall maintain a waiting ~~wait~~ list of clients placed in the order of the date that the client is determined eligible for waiver services.

(6) The agency shall allow an individual who meets the eligibility requirements under s. 393.065(1) to receive home and community-based services in this state if the individual's parent or legal guardian is an active-duty military servicemember and if at the time of the servicemember's transfer to this state, the individual was receiving home and community-based services in another state.

(7)~~(6)~~ The client, the client's guardian, or the client's family must ensure that accurate, up-to-date contact information is provided to the agency at all times. Notwithstanding s. 393.0651, in lieu of an annual report, the agency shall send an annual letter requesting updated information from the client, the client's guardian, or the client's family. The agency shall remove from the waiting ~~wait~~ list any individual who cannot be located using the contact information provided to the agency, fails to meet eligibility requirements, or becomes domiciled

outside the state.

(8) Once individuals on the waiting list are selected to receive waiver services pursuant to this section, an individual remaining on the waiting list is deemed not to have been substantially affected by agency action and therefore is not entitled to a hearing under s. 393.125 or an administrative proceeding under chapter 120.

(9)~~(7)~~ The agency and the Agency for Health Care Administration may adopt rules specifying application procedures~~;~~ criteria associated with waiting-list ~~wait-list~~ categories~~;~~ procedures for administering the waiting ~~wait~~ list, including, but not limited to, tools for prioritizing waiver enrollment within categories; and eligibility criteria as needed to administer this section.

Section 3. Subsection (2) of section 393.066, Florida Statutes, is amended to read:

393.066 Community services and treatment.—

(2) All services needed shall be purchased instead of provided directly by the agency, when such arrangement is more cost-efficient than having those services provided directly. All purchased services must be approved by the agency. All persons or entities under contract with the agency to provide services shall use agency data management systems to document service provision to clients. Contracted persons and entities shall meet the minimum hardware and software technical requirements for use of such systems established by the agency. Such persons or

entities shall also meet requirements for training and professional development of staff providing direct services to clients as established by the agency.

Section 4. Paragraph (b) of subsection (1) of section 393.0662, Florida Statutes, is amended to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget. Therefore, the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, develop and implement a comprehensive redesign of the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(1) The agency shall establish an individual budget, referred to as an iBudget, for each individual served by the home and community-based services Medicaid waiver program. The

funds appropriated to the agency shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. For the iBudget system, eligible clients shall include individuals with ~~a diagnosis of Down syndrome or~~ a developmental disability as defined in s. 393.063. The iBudget system shall be designed to provide for: enhanced client choice within a specified service package; appropriate assessment strategies; an efficient consumer budgeting and billing process that includes reconciliation and monitoring components; a redefined role for support coordinators that avoids potential conflicts of interest; a flexible and streamlined service review process; and a methodology and process that ensures the equitable allocation of available funds to each client based on the client's level of need, as determined by the variables in the allocation algorithm.

(b) The allocation methodology shall provide the algorithm that determines the amount of funds allocated to a client's iBudget. The agency may approve an increase in the amount of funds allocated, as determined by the algorithm, based on the client having one or more of the following needs that cannot be accommodated within the funding as determined by the algorithm and having no other resources, supports, or services available to meet the need:

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in immediate, serious jeopardy unless the increase is approved. An

extraordinary need may include, but is not limited to:

a. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

b. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

c. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a medical condition existing simultaneously but independently with another medical condition in a patient; or

d. A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

2. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy, unless the increase is approved. A significant need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or

special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term "temporary" means a period of fewer than 12 continuous months. However, the presence of such significant need for one-time or temporary supports or services alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

3. A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy because of substantial changes in the client's circumstances, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the state Medicaid plan due to a change in age, or a significant change in medical or functional status which requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client's current iBudget. As used in this subparagraph, the term "long-term" means a period of 12 or more continuous months. However, such significant increase in need for services of a permanent or long-term nature alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm.

4. A significant need for transportation services to a waiver-funded adult day training program or to waiver-funded

employment services when such need cannot be accommodated within the funding authorized by the client's iBudget amount without affecting the health and safety of the client, when public transportation is not an option due to the unique needs of the client, and when no other transportation resources are reasonably available.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for adjustments required pursuant to this paragraph and may use the services of an independent actuary in determining the amount of the portions to be reserved.

Section 5. Section 393.0679, Florida Statutes, is created to read:

393.0679 Utilization review.—The agency shall conduct utilization review activities in public and private intermediate care facilities for individuals with developmental disabilities as necessary to meet the requirements of the approved Medicaid state plan and federal law. All private intermediate care facilities for individuals with developmental disabilities shall comply with any requests for information and documentation and permit any inspections necessary for the agency to conduct such activities.

Section 6. This act shall take effect July 1, 2016.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Renner offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 393.063, Florida Statutes, is amended to read:

393.063 Definitions.—For the purposes of this chapter, the term:

(2) ~~(1)~~ "Agency" means the Agency for Persons with Disabilities.

(1) ~~(2)~~ "Adult day training" means training services that ~~which~~ take place in a nonresidential setting, separate from the home or facility in which the client resides, and~~,~~ are intended to support the participation of clients in daily, meaningful,

and valued routines of the community. Such training~~; and~~ may be provided in ~~include~~ work-like settings that do not meet the definition of supported employment.

(3) "Algorithm" means the mathematical formula used by the agency to calculate amounts for clients which uses variables that have statistically validated relationships to clients' needs for services provided by the home and community based Medicaid Waiver program.

(4) "Allocation methodology" is the process used to determine a client's iBudget by summing the amount generated by the algorithm, and, if applicable, any funding authorized by the agency for the client pursuant to s. 393.0662(1)(b).

(5)~~(3)~~ "Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

(6)~~(4)~~ "Cerebral palsy" means a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before, during, or after birth and that results in the loss or impairment of control over voluntary muscles. For the purposes of this definition, cerebral

palsy does not include those symptoms or impairments resulting solely from a stroke.

(7) ~~(5)~~ "Client" means any person determined eligible by the agency for services under this chapter.

(8) ~~(6)~~ "Client advocate" means a friend or relative of the client, or of the client's immediate family, who advocates for the best interests of the client in any proceedings under this chapter in which the client or his or her family has the right or duty to participate.

(9) ~~(7)~~ "Comprehensive assessment" means the process used to determine eligibility for services under this chapter.

(10) ~~(8)~~ "Comprehensive transitional education program" means the program established in s. 393.18.

(12) ~~(9)~~ "Developmental disability" means a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

(11) ~~(10)~~ "Developmental disabilities center" means a state-owned and state-operated facility, formerly known as a "Sunland Center," providing for the care, habilitation, and rehabilitation of clients with developmental disabilities.

(13) ~~(11)~~ "Direct service provider" means a person 18 years of age or older who has direct face-to-face contact with a client while providing services to the client or has access to a

client's living areas or to a client's funds or personal property.

(14) ~~(12)~~ "Domicile" means the place where a client legally resides and~~,~~ which ~~place~~ is his or her permanent home. Domicile may be established as provided in s. 222.17. Domicile may not be established in Florida by a minor who has no parent domiciled in Florida, or by a minor who has no legal guardian domiciled in Florida, or by any alien not classified as a resident alien.

(15) ~~(13)~~ "Down syndrome" means a disorder caused by the presence of an extra chromosome 21.

(16) ~~(14)~~ "Express and informed consent" means consent voluntarily given in writing with sufficient knowledge and comprehension of the subject matter to enable the person giving consent to make a knowing decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

(17) ~~(15)~~ "Family care program" means the program established in s. 393.068.

(18) ~~(16)~~ "Foster care facility" means a residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to meet the physical, emotional, and social needs of its residents. The capacity of such a facility may not be more than three residents.

(19) ~~(17)~~ "Group home facility" means a residential facility licensed under this chapter which provides a family living environment including supervision and care necessary to

meet the physical, emotional, and social needs of its residents. The capacity of such a facility shall be at least 4 but not more than 15 residents.

(20) "Guardian" has the same meaning as in s. 744.102.

(21) ~~(18)~~ "Guardian advocate" means a person appointed by a written order of the court to represent a person with developmental disabilities under s. 393.12.

(22) ~~(19)~~ "Habilitation" means the process by which a client is assisted in acquiring and maintaining ~~to acquire and maintain~~ those life skills that ~~which~~ enable the client to cope more effectively with the demands of his or her condition and environment and to raise the level of his or her physical, mental, and social efficiency. It includes, but is not limited to, programs of formal structured education and treatment.

(23) ~~(20)~~ "High-risk child" means, for the purposes of this chapter, a child from 3 to 5 years of age with one or more of the following characteristics:

(a) A developmental delay in cognition, language, or physical development.

(b) A child surviving a catastrophic infectious or traumatic illness known to be associated with developmental delay, when funds are specifically appropriated.

(c) A child with a parent or guardian with developmental disabilities who requires assistance in meeting the child's developmental needs.

(d) A child who has a physical or genetic anomaly associated with developmental disability.

(24) ~~(21)~~ "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to continue indefinitely. For the purposes of this definition, the term:

(a) "Adaptive behavior" means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.

(b) "Significantly subaverage general intellectual functioning" means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency.

For purposes of the application of the criminal laws and procedural rules of this state to matters relating to pretrial, trial, sentencing, and any matters relating to the imposition and execution of the death penalty, the terms "intellectual disability" or "intellectually disabled" are interchangeable with and have the same meaning as the terms "mental retardation" or "retardation" and "mentally retarded" as defined in this section before July 1, 2013.

(25) ~~(22)~~ "Intermediate care facility for the developmentally disabled" ~~or "ICF/DD"~~ means a residential facility licensed and certified under part VIII of chapter 400.

(26) ~~(23)~~ "Medical/dental services" means medically necessary services that are provided or ordered for a client by a person licensed under chapter 458, chapter 459, or chapter 466. Such services may include, but are not limited to, prescription drugs, specialized therapies, nursing supervision, hospitalization, dietary services, prosthetic devices, surgery, specialized equipment and supplies, adaptive equipment, and other services as required to prevent or alleviate a medical or dental condition.

(27) ~~(24)~~ "Personal care services" means individual assistance with or supervision of essential activities of daily living for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar services that are incidental to the care furnished and essential to the health, safety, and welfare of the client if no one else is available to perform those services.

(28) ~~(25)~~ "Prader-Willi syndrome" means an inherited condition typified by neonatal hypotonia with failure to thrive, hyperphagia or an excessive drive to eat which leads to obesity usually at 18 to 36 months of age, mild to moderate intellectual disability, hypogonadism, short stature, mild facial dysmorphism, and a characteristic neurobehavior.

(29) ~~(26)~~ "Relative" means an individual who is connected by affinity or consanguinity to the client and who is 18 years of age or older.

(30) ~~(27)~~ "Resident" means a person who has a developmental disability and resides at a residential facility, whether or not such person is a client of the agency.

(31) ~~(28)~~ "Residential facility" means a facility providing room and board and personal care for persons who have developmental disabilities.

(32) ~~(29)~~ "Residential habilitation" means supervision and training with the acquisition, retention, or improvement in skills related to activities of daily living, such as personal hygiene skills, homemaking skills, and the social and adaptive skills necessary to enable the individual to reside in the community.

(33) ~~(30)~~ "Residential habilitation center" means a community residential facility licensed under this chapter which provides habilitation services. The capacity of such a facility may not be fewer than nine residents. After October 1, 1989, new residential habilitation centers may not be licensed and the licensed capacity for any existing residential habilitation center may not be increased.

(34) ~~(31)~~ "Respite service" means appropriate, short-term, temporary care that is provided to a person who has a developmental disability in order to meet the planned or

emergency needs of the person or the family or other direct service provider.

(35) ~~(32)~~ "Restraint" means a physical device, method, or drug used to control dangerous behavior.

(a) A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to an individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.

(b) A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not a standard treatment for the person's medical or psychiatric condition. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

(c) Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding necessary for routine physical examinations and tests; for purposes of orthopedic, surgical, or other similar medical treatment; to provide support for the achievement of functional body position or proper balance; or to protect a person from falling out of bed.

(36) ~~(33)~~ "Seclusion" means the involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff

member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For the purposes of this chapter, the term does not mean isolation due to the medical condition or symptoms of the person.

(37) ~~(34)~~ "Self-determination" means an individual's freedom to exercise the same rights as all other citizens, authority to exercise control over funds needed for one's own support, including prioritizing these funds when necessary, responsibility for the wise use of public funds, and self-advocacy to speak and advocate for oneself in order to gain independence and ensure that individuals with a developmental disability are treated equally.

(38) ~~(35)~~ "Specialized therapies" means those treatments or activities prescribed by and provided by an appropriately trained, licensed, or certified professional or staff person and may include, but are not limited to, physical therapy, speech therapy, respiratory therapy, occupational therapy, behavior therapy, physical management services, and related specialized equipment and supplies.

(39) ~~(36)~~ "Spina bifida" means~~, for purposes of this chapter,~~ a person with a medical diagnosis of spina bifida cystica or myelomeningocele.

(40) ~~(37)~~ "Support coordinator" means a person who is designated by the agency to assist individuals and families in identifying their capacities, needs, and resources, as well as finding and gaining access to necessary supports and services;

coordinating the delivery of supports and services; advocating on behalf of the individual and family; maintaining relevant records; and monitoring and evaluating the delivery of supports and services to determine the extent to which they meet the needs and expectations identified by the individual, family, and others who participated in the development of the support plan.

(41) ~~(38)~~ "Supported employment" means employment located or provided in an integrated work setting, with earnings paid on a commensurate wage basis, and for which continued support is needed for job maintenance.

(42) ~~(39)~~ "Supported living" means a category of individually determined services designed and coordinated in such a manner as to provide assistance to adult clients who require ongoing supports to live as independently as possible in their own homes, to be integrated into the community, and to participate in community life to the fullest extent possible.

(43) ~~(40)~~ "Training" means a planned approach to assisting a client to attain or maintain his or her maximum potential and includes services ranging from sensory stimulation to instruction in skills for independent living and employment.

(44) ~~(41)~~ "Treatment" means the prevention, amelioration, or cure of a client's physical and mental disabilities or illnesses.

Section 2. Section 393.0641, Florida Statutes, is repealed.

Section 3. Subsections (3) and (5) of section 393.065, Florida Statutes, are amended, present subsections (6) and (7) of that section are amended and redesignated as subsections (7) and (9), respectively, and new subsections (6) and (8) are added to that section, to read:

393.065 Application and eligibility determination.—

(3) The agency shall notify each applicant, in writing, of its eligibility decision. Any applicant determined by the agency to be ineligible for ~~developmental~~ services has the right to appeal this decision pursuant to ss. 120.569 and 120.57.

(5) ~~Except as otherwise directed by law, beginning July 1, 2010,~~ The agency shall assign and provide priority to clients waiting for waiver services in the following order:

(a) Category 1, which includes clients deemed to be in crisis as described in rule, shall be given first priority in moving from the waiting list to the waiver.

(b) Category 2, which includes individuals on the waiting ~~children on the wait~~ list who are:

1. From the child welfare system with an open case in the Department of Children and Families' statewide automated child welfare information system and who are either:

a. Transitioning out of the child welfare system at the finalization of an adoption, a reunification with family members, a permanent placement with a relative, or a guardianship with a nonrelative; or

b. At least 18 years old but not yet 22 years old and who

need both waiver services and extended foster care services.

2. At least 18 years old but not yet 22 years old and who withdrew consent pursuant to s. 39.6251(5)(c) to remain in the extended foster care system.

For individuals who are at least 18 years old but not yet 22 years old and who are eligible under sub-subparagraph 1.b., the agency shall provide waiver services, including residential habilitation, and the community-based care lead agency shall fund room and board at the rate established in s. 409.145(4) and provide case management and related services as defined in s. 409.986(3)(e). Individuals may receive both waiver services and services under s. 39.6251. Services may not duplicate services available through the Medicaid state plan.

(c) Category 3, which includes, but is not required to be limited to, clients:

1. Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;

2. At substantial risk of incarceration or court commitment without supports;

3. Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or

4. Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available or whose caregiver is unable to provide the care needed.

(d) Category 4, which includes, but is not required to be limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available.

(e) Category 5, which includes, but is not required to be limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain a meaningful day activity, ~~or~~ maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.

(f) Category 6, which includes clients 21 years of age or older who do not meet the criteria for category 1, category 2, category 3, category 4, or category 5.

(g) Category 7, which includes clients younger than 21 years of age who do not meet the criteria for category 1, category 2, category 3, or category 4.

Within categories 3, 4, 5, 6, and 7, the agency shall maintain a waiting ~~wait~~ list of clients placed in the order of the date that the client is determined eligible for waiver services.

(6) The agency shall allow an individual who meets the eligibility requirements under subsection (1) to receive home and community-based services in this state if the individual's parent or legal guardian is an active-duty military service member and if at the time of the service member's transfer to this state, the individual was receiving home and community-based services in another state.

(7) ~~(6)~~ The client, the client's guardian, or the client's family must ensure that accurate, up-to-date contact information is provided to the agency at all times. Notwithstanding s. 393.0651, the agency shall send an annual letter requesting updated information from the client, the client's guardian, or the client's family. The agency shall remove from the waiting ~~wait~~ list any individual who cannot be located using the contact information provided to the agency, fails to meet eligibility requirements, or becomes domiciled outside the state.

(8) Agency action that selects individuals to receive waiver services pursuant to this section does not establish a right to a hearing or an administrative proceeding under chapter 120 for individuals remaining on the waiting list.

(9) ~~(7)~~ The agency and the Agency for Health Care Administration may adopt rules specifying application procedures, criteria associated with the waiting list ~~wait-list~~ categories, procedures for administering the waiting ~~wait~~ list, including tools for prioritizing waiver enrollment within

categories, and eligibility criteria as needed to administer this section.

Section 4. Subsection (2) of section 393.066, Florida Statutes, is amended to read:

393.066 Community services and treatment.—

(2) Necessary ~~All~~ services ~~needed~~ shall be purchased, rather than ~~instead of~~ provided directly by the agency, when the purchase of services ~~such arrangement~~ is more cost-efficient than providing them ~~having those services provided~~ directly. All purchased services must be approved by the agency. Persons or entities under contract with the agency to provide services shall use agency data management systems to document service provision to clients. Contracted persons and entities shall meet the minimum hardware and software technical requirements established by the agency for the use of such systems. Such persons or entities shall also meet any requirements established by the agency for training and professional development of staff providing direct services to clients.

Section 5. Section 393.0662, Florida Statutes, is amended to read:

393.0662 Individual budgets for delivery of home and community-based services; iBudget system established.—The Legislature finds that improved financial management of the existing home and community-based Medicaid waiver program is necessary to avoid deficits that impede the provision of services to individuals who are on the waiting list for

enrollment in the program. The Legislature further finds that clients and their families should have greater flexibility to choose the services that best allow them to live in their community within the limits of an established budget. Therefore, the Legislature intends that the agency, in consultation with the Agency for Health Care Administration, shall manage ~~develop and implement a comprehensive redesign of~~ the service delivery system using individual budgets as the basis for allocating the funds appropriated for the home and community-based services Medicaid waiver program among eligible enrolled clients. The service delivery system that uses individual budgets shall be called the iBudget system.

(1) The agency shall administer ~~establish~~ an individual budget, referred to as an iBudget, for each individual served by the home and community-based services Medicaid waiver program. The funds appropriated to the agency shall be allocated through the iBudget system to eligible, Medicaid-enrolled clients. For the iBudget system, eligible clients shall include individuals with ~~a diagnosis of Down syndrome or~~ a developmental disability as defined in s. 393.063. The iBudget system shall ~~be designed to~~ provide for: enhanced client choice within a specified service package; appropriate assessment strategies; an efficient consumer budgeting and billing process that includes reconciliation and monitoring components; a ~~redefined~~ role for support coordinators that avoids potential conflicts of interest; a flexible and streamlined service review process; and

~~a methodology and process that ensures~~ the equitable allocation of available funds ~~to each client~~ based on the client's level of need, as determined by the ~~variables in the~~ allocation methodology ~~algorithm~~.

(a) In developing each client's iBudget, the agency shall use the allocation ~~an allocation algorithm and~~ methodology as defined in s. 393.063(4). ~~The algorithm shall use variables that have been determined by the agency to have a statistically validated relationship to the client's level of need for services provided through the home and community based services Medicaid waiver program. The algorithm and methodology may consider individual characteristics, including, but not limited to, a client's age and living situation, information from a formal assessment instrument that the agency determines is valid and reliable, and information from other assessment processes.~~

~~(b)~~ The allocation methodology shall determine ~~provide the algorithm that determines~~ the amount of funds allocated to a client's iBudget.

(b) The agency may authorize funding ~~approve an increase in the amount of funds allocated, as determined by the algorithm,~~ based on a ~~the~~ client having one or more of the following needs that cannot be accommodated within the funding ~~as~~ determined by the algorithm and having no other resources, supports, or services available to meet the need:

1. An extraordinary need that would place the health and safety of the client, the client's caregiver, or the public in

immediate, serious jeopardy unless the increase is approved. However, the presence of an extraordinary need in and of itself does not warrant authorized funding by the agency. An extraordinary need may include, but is not limited to:

a. A documented history of significant, potentially life-threatening behaviors, such as recent attempts at suicide, arson, nonconsensual sexual behavior, or self-injurious behavior requiring medical attention;

b. A complex medical condition that requires active intervention by a licensed nurse on an ongoing basis that cannot be taught or delegated to a nonlicensed person;

c. A chronic comorbid condition. As used in this subparagraph, the term "comorbid condition" means a medical condition existing simultaneously but independently with another medical condition in a patient; or

d. A need for total physical assistance with activities such as eating, bathing, toileting, grooming, and personal hygiene.

~~However, the presence of an extraordinary need alone does not warrant an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm~~.

2. A significant need for one-time or temporary support or services that, if not provided, would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy~~, unless the increase is approved~~. A significant

need may include, but is not limited to, the provision of environmental modifications, durable medical equipment, services to address the temporary loss of support from a caregiver, or special services or treatment for a serious temporary condition when the service or treatment is expected to ameliorate the underlying condition. As used in this subparagraph, the term "temporary" means a period of fewer than 12 continuous months. However, the presence of such significant need for one-time or temporary supports or services alone does not warrant authorized funding by the agency ~~an increase in the amount of funds allocated to a client's iBudget as determined by the algorithm~~.

3. A significant increase in the need for services after the beginning of the service plan year that would place the health and safety of the client, the client's caregiver, or the public in serious jeopardy because of substantial changes in the client's circumstances, including, but not limited to, permanent or long-term loss or incapacity of a caregiver, loss of services authorized under the state Medicaid plan due to a change in age, or a significant change in medical or functional status which requires the provision of additional services on a permanent or long-term basis that cannot be accommodated within the client's current iBudget. As used in this subparagraph, the term "long-term" means a period of 12 or more continuous months. However, such significant increase in need for services of a permanent or long-term nature ~~alone~~ does not in and of itself warrant authorized funding by the agency ~~an increase in the amount of~~

~~funds allocated to a client's iBudget as determined by the algorithm~~.

4. A significant need for transportation services to a waiver-funded adult day training program or to waiver-funded employment services when such need cannot be accommodated within a client's iBudget as determined by the algorithm without affecting the health and safety of the client, if public transportation is not an option due to the unique needs of the client or other transportation resources are not reasonably available.

The agency shall reserve portions of the appropriation for the home and community-based services Medicaid waiver program for adjustments required pursuant to this paragraph and may use the services of an independent actuary in determining the amount ~~of the portions~~ to be reserved.

(c) ~~A client's iBudget shall be the total of the amount determined by the algorithm and any additional funding provided pursuant to paragraph (b).~~ A client's annual expenditures for home and community-based ~~services~~ Medicaid waiver services may not exceed the limits of his or her iBudget. The total of all clients' projected annual iBudget expenditures may not exceed the agency's appropriation for waiver services.

(2) The Agency for Health Care Administration, in consultation with the agency, shall seek federal approval to amend current waivers, request a new waiver, and amend contracts

as necessary to manage the iBudget system, to improve services for eligible and enrolled clients, and to improve the delivery of services ~~implement the iBudget system to serve eligible, enrolled clients~~ through the home and community-based services Medicaid waiver program and the Consumer-Directed Care Plus Program including but not limited to enrollees with a dual diagnosis of a developmental disability and a mental health diagnosis.

~~(3) The agency shall transition all eligible, enrolled clients to the iBudget system. The agency may gradually phase in the iBudget system.~~

~~(a) While the agency phases in the iBudget system, the agency may continue to serve eligible, enrolled clients under the four-tiered waiver system established under s. 393.065 while those clients await transitioning to the iBudget system.~~

~~(b) The agency shall design the phase-in process to ensure that a client does not experience more than one-half of any expected overall increase or decrease to his or her existing annualized cost plan during the first year that the client is provided an iBudget due solely to the transition to the iBudget system.~~

(3) ~~(4)~~ A client must use all available services authorized under the state Medicaid plan, school-based services, private insurance and other benefits, and any other resources that may be available to the client before using funds from his or her iBudget to pay for support and services.

~~(5) The service limitations in s. 393.0661(3)(f)1., 2., and 3. do not apply to the iBudget system.~~

(4) ~~(6)~~ Rates for any or all services established under rules of the Agency for Health Care Administration must ~~shall~~ be designated as the maximum rather than a fixed amount for individuals who receive an iBudget, except for services specifically identified in those rules that the agency determines are not appropriate for negotiation, which may include, but are not limited to, residential habilitation services.

(5) ~~(7)~~ The agency shall ensure that clients and caregivers have access to training and education that ~~to~~ inform them about the iBudget system and enhance their ability for self-direction. Such training and education must ~~shall~~ be offered in a variety of formats and, at a minimum, must ~~shall~~ address the policies and processes of the iBudget system and~~,~~ the roles and responsibilities of consumers, caregivers, waiver support coordinators, providers, and the agency, and must provide~~,~~ information ~~available~~ to help the client make decisions regarding the iBudget system~~,~~ and examples of support and resources available in the community.

(6) ~~(8)~~ The agency shall collect data to evaluate the implementation and outcomes of the iBudget system.

(7) ~~(9)~~ The agency and the Agency for Health Care Administration may adopt rules specifying the allocation algorithm and methodology; criteria and processes for clients to

access reserved funds for extraordinary needs, temporarily or permanently changed needs, and one-time needs; and processes and requirements for selection and review of services, development of support and cost plans, and management of the iBudget system as needed to administer this section.

Section 6. Section 393.0679, Florida Statutes, is created to read:

393.0679 Utilization review.—The agency shall conduct utilization review activities in intermediate care facilities for individuals with developmental disabilities, both public and private, as necessary to meet the requirements of the approved Medicaid state plan and federal law, and such facilities shall comply with any requests for information and documentation made by the agency and permit any agency inspections in connection with such activities.

Section 7. Subsection (1), paragraphs (a) and (b) of subsection (4), paragraphs (b), (e), (f), (g), and (h) of subsection (5), subsection (6), paragraph (d) of subsection (7), subsection (10), and paragraph (b) of subsection (12) of section 393.11, Florida Statutes, are amended, and subsection (14) is added to that section, to read:

393.11 Involuntary admission to residential services.—

(1) JURISDICTION.—If a person has an intellectual disability or autism and requires involuntary admission to residential services provided by the agency, the circuit court of the county in which the person resides has jurisdiction to

conduct a hearing and enter an order involuntarily admitting the person in order for the person to receive the care, treatment, habilitation, and rehabilitation that the person needs. For the purpose of identifying intellectual disability or autism, diagnostic capability shall be established by the agency. Except as otherwise specified, the proceedings under this section are governed by the Florida Rules of Civil Procedure.

(4) AGENCY PARTICIPATION.—

(a) Upon receiving the petition, the court shall immediately order the ~~developmental services program of the~~ agency to examine the person being considered for involuntary admission to residential services.

(b) Following examination, the agency shall file a written report with the court at least 10 working days before the date of the hearing. The report must be served on the petitioner, the person who has the intellectual disability or autism, and the person's attorney at the time the report is filed with the court.

(5) EXAMINING COMMITTEE.—

(b) The court shall appoint at least three disinterested experts who have demonstrated to the court an expertise in the diagnosis, evaluation, and treatment of persons who have intellectual disabilities or autism. The committee must include at least one licensed and qualified physician, one licensed and qualified psychologist, and one qualified professional who, at a minimum, has a master's degree in social work, special

education, or vocational rehabilitation counseling, to examine the person and to testify at the hearing on the involuntary admission to residential services.

(e) The committee shall prepare a written report for the court. The report must explicitly document the extent that the person meets the criteria for involuntary admission. The report, and expert testimony, must include, but not be limited to:

1. The degree of the person's intellectual disability or autism and whether, using diagnostic capabilities established by the agency, the person is eligible for agency services;

2. Whether, because of the person's degree of intellectual disability or autism, the person:

a. Lacks sufficient capacity to give express and informed consent to a voluntary application for services pursuant to s. 393.065 and lacks basic survival and self-care skills to such a degree that close supervision and habilitation in a residential setting is necessary and, if not provided, would result in a threat of substantial harm to the person's well-being; or

~~b. Lacks basic survival and self-care skills to such a degree that close supervision and habilitation in a residential setting is necessary and if not provided would result in a real and present threat of substantial harm to the person's well-being; or~~

b.~~c.~~ Is likely to physically injure others if allowed to remain at liberty.

3. The purpose to be served by residential care;

4. A recommendation on the type of residential placement which would be the most appropriate and least restrictive for the person; and

5. The appropriate care, habilitation, and treatment.

(f) The committee shall file the report with the court at least 10 working days before the date of the hearing. The report must be served on the petitioner, the person who has the intellectual disability or autism, the person's attorney at the time the report is filed with the court, and the agency.

(g) Members of the examining committee shall receive a reasonable fee to be determined by the court. The fees shall be paid from the general revenue fund of the county in which the person who has the intellectual disability or autism resided when the petition was filed.

~~(h) The agency shall develop and prescribe by rule one or more standard forms to be used as a guide for members of the examining committee.~~

(6) COUNSEL; GUARDIAN AD LITEM.—

(a) The person who has the intellectual disability or autism must be represented by counsel at all stages of the judicial proceeding. If the person is indigent and cannot afford counsel, the court shall appoint a public defender at least 20 working days before the scheduled hearing. The person's counsel shall have full access to the records of the service provider and the agency. In all cases, the attorney shall represent the

rights and legal interests of the person, regardless of who initiates the proceedings or pays the attorney ~~attorney's~~ fee.

(b) If the attorney, during the course of his or her representation, reasonably believes that the person who has the intellectual disability or autism cannot adequately act in his or her own interest, the attorney may seek the appointment of a guardian ad litem. A prior finding of incompetency is not required before a guardian ad litem is appointed pursuant to this section.

(7) HEARING.—

(d) The person who has the intellectual disability or autism must be physically present throughout the entire proceeding. If the person's attorney believes that the person's presence at the hearing is not in his or her best interest, the person's presence may be waived once the court has seen the person and the hearing has commenced.

(10) COMPETENCY.—

(a) The issue of competency is separate and distinct from a determination of the appropriateness of involuntary admission to residential services due to intellectual disability or autism.

(b) The issue of the competency of a person who has an intellectual disability or autism for purposes of assigning guardianship shall be determined in a separate proceeding according to the procedures and requirements of chapter 744. The issue of the competency of a person who has an intellectual

disability or autism for purposes of determining whether the person is competent to proceed in a criminal trial shall be determined in accordance with chapter 916.

(12) APPEAL.—

(b) The filing of an appeal by the person who has an intellectual disability or autism stays admission of the person into residential care. The stay remains in effect during the pendency of all review proceedings in Florida courts until a mandate issues.

(14) REVIEW OF CONTINUED INVOLUNTARY ADMISSION TO RESIDENTIAL SERVICES.—

(a) If a person is involuntarily admitted to residential services provided by the agency, the agency shall employ or, if necessary, contract with a qualified evaluator to conduct a review annually, unless otherwise ordered, to determine the propriety of the person's continued involuntary admission to residential services based on the criteria in paragraph (8)(b). The review shall include an assessment of the most appropriate and least restrictive type of residential placement for the person.

(b) A placement resulting from an involuntary admission to residential services must be reviewed by the court at a hearing annually, unless a shorter review period is ordered at a previous hearing. The agency shall provide to the court the completed reviews by the qualified evaluator. The review and hearing must determine whether the person continues to meet the

criteria in paragraph (8)(b) and, if so, whether the person still requires involuntary placement in a residential setting and whether the person is receiving adequate care, treatment, habilitation, and rehabilitation in the residential setting.

(c) The agency shall provide a copy of the review and reasonable notice of the hearing to the appropriate state attorney, if applicable, the person's attorney, and the person's guardian or guardian advocate, if appointed.

(d) For purposes of this section, the term "qualified evaluator" means a psychiatrist licensed under chapter 458 or chapter 459, or a psychologist licensed under chapter 490, who has demonstrated to the court an expertise in the diagnosis, evaluation, and treatment of persons who have intellectual disabilities.

Section 8. Effective June 30, 2016, or if this act fails to become law until after that date, operating retroactively to June 30, 2016, sections 24 and 26 of ch. 2015-222, Laws of Florida, are repealed.

Section 9. Subsection (15) of section 393.067, Florida Statutes, is reenacted to read:

393.067 Facility licensure.—

(15) The agency is not required to contract with facilities licensed pursuant to this chapter.

Section 10. Subsection (4) of section 393.18, Florida Statutes, is reenacted to read:

393.18 Comprehensive transitional education program.—A comprehensive transitional education program is a group of jointly operating centers or units, the collective purpose of which is to provide a sequential series of educational care, training, treatment, habilitation, and rehabilitation services to persons who have developmental disabilities and who have severe or moderate maladaptive behaviors. However, this section does not require such programs to provide services only to persons with developmental disabilities. All such services shall be temporary in nature and delivered in a structured residential setting, having the primary goal of incorporating the principle of self-determination in establishing permanent residence for persons with maladaptive behaviors in facilities that are not associated with the comprehensive transitional education program. The staff shall include behavior analysts and teachers, as appropriate, who shall be available to provide services in each component center or unit of the program. A behavior analyst must be certified pursuant to s. 393.17.

(4) For comprehensive transitional education programs, the total number of residents who are being provided with services may not in any instance exceed the licensed capacity of 120 residents and each residential unit within the component centers of the program authorized under this section may not in any instance exceed 15 residents. However, a program that was authorized to operate residential units with more than 15

residents before July 1, 2015, may continue to operate such units.

Section 11. Paragraph (b) of subsection (1) of section 383.141, Florida Statutes, is amended to read:

383.141 Prenatally diagnosed conditions; patient to be provided information; definitions; information clearinghouse; advisory council.—

(1) As used in this section, the term:

(b) "Developmental disability" includes Down syndrome and other developmental disabilities defined by s. 393.063(12) ~~s. 393.063(9)~~.

Section 12. Paragraph (d) of subsection (2) of section 1002.385, Florida Statutes, is amended to read:

1002.385 Florida personal learning scholarship accounts.—

(2) DEFINITIONS.—As used in this section, the term:

(d) "Disability" means, for a 3- or 4-year-old child or for a student in kindergarten to grade 12, autism spectrum disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association; cerebral palsy, as defined in s. 393.063(6) ~~s. 393.063(4)~~; Down syndrome, as defined in s. 393.063(15) ~~s. 393.063(13)~~; an intellectual disability, as defined in s. 393.063(24) ~~s. 393.063(21)~~; Prader-Willi syndrome, as defined in s. 393.063(28) ~~s. 393.063(25)~~; or spina bifida, as defined in s. 393.063(39) ~~s. 393.063(36)~~; for a student in kindergarten, being a high-risk child, as defined in s.

393.063(23)(a) ~~s. 393.063(20)(a)~~; muscular dystrophy; and Williams syndrome.

Section 13. For the 2016-2017 fiscal year, the sum of $623,200 in nonrecurring funds from the General Revenue Fund is appropriated to the Agency for Persons with Disabilities for the purpose of implementing this act.

Section 14. Except as otherwise provided herein, this act shall take effect July 1, 2016.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert: An act relating to the Agency for Persons with Disabilities; amending s. 393.063, F.S.; revising and defining terms; repealing s. 393.0641, F.S., relating to a program for the prevention and treatment of severe self-injurious behavior; amending s. 393.065, F.S.; providing for the assignment of priority to clients waiting for waiver services; requiring an agency to allow a certain individual to receive such services if the individual's parent or legal guardian is an active-duty military service member; requiring the agency to send an annual letter to clients and their guardians or families; providing that certain agency action does not establish a right to a hearing or an administrative proceeding; amending s. 393.066, F.S.; providing for the use of an agency data management system; providing requirements for persons or entities under contract

with the agency; amending s. 393.0662, F.S.; adding client needs that qualify as extraordinary needs, which may result in the approval of an increase in a client's allocated funds; revising duties of the Agency for Health Care Administration relating to the iBudget system; creating s. 393.0679, F.S.; requiring the Agency for Persons with Disabilities to conduct a certain utilization review; requiring certain intermediate care facilities to comply with certain requests and inspections by the agency; amending s. 393.11, F.S.; providing for annual reviews for persons involuntarily admitted to residential services provided by the agency; requiring the agency to contract with a qualified evaluator; providing requirements for annual reviews; requiring a hearing to be held to consider the results of an annual review; requiring the agency to provide a copy of the review to certain persons; defining a term; repealing ss. 24 and 26 of chapter 2015-222, Laws of Florida; abrogating the scheduled expiration and reversion of amendments to ss. 393.067(15) and 393.18, F.S., relating to requirement to contract with licensed facilities and capacity of comprehensive transitional education programs and the residential units of their component centers; amending ss. 383.141 and 1002.385, F.S.; conforming cross-references to changes made by the act; providing an appropriation; providing effective dates.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1245 Medicaid Provider Overpayments
SPONSOR(S): Peters
TIED BILLS: **IDEN./SIM. BILLS:** SB 1370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	McElroy	Poche
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Clark	Pridgeon
3) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

In the Florida Medicaid program, the state has one year from the date that the Agency for Health Care Administration (AHCA) or federal Centers for Medicare & Medicaid Services (CMS) discover an overpayment to a Medicaid provider to recover or seek to recover the overpayment. After the one-year period, Florida must refund the federal share of the overpayment, regardless of whether AHCA has actually recovered payment from the Medicaid provider. Federal law provides an exemption from repayment if the Medicaid provider has gone out of business. To use this exemption, AHCA must certify that a Medicaid provider is out of business and that any overpayment cannot be collected. AHCA does not currently have statutory authority to make this certification and, as a result, Florida repays the federal share of the overpayments to out-of-business Medicaid providers. The annual repayment amount has ranged from $1.5 million to $7.3 million.

HB 1245 authorizes AHCA to certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected. This allows Florida to use the exemption from any mandatory repayment of the federal share for Medicaid provider overpayments.

The bill appears to have an indeterminate, positive fiscal impact on state government. There is no fiscal impact to local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a jointly funded partnership of the federal and state governments that provides access to health care for low-income families and individuals. The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government[1], as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states.

The Centers for Medicare & Medicaid Services (CMS), within the U.S. Department of Health and Human Services, is responsible for the administration of the Medicaid program. CMS, through its Center for Program Integrity, is tasked with identifying, prosecuting and preventing fraud, waste and abuse within the Medicaid program.[2] To accomplish this task, CMS has authority to:

- Hire contractors to review provider activities, audit claims, identify overpayments, and educate providers and others on program integrity issues;
- Provide support and assistance to states in their efforts to combat provider fraud and abuse; and
- Eliminate and recover improper payments.

Medicaid Program in Florida

The Medicaid program in Florida is administered by the Agency for Health Care Administration (AHCA). Reimbursement for services provided to Medicaid recipients is established through various methodologies which may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding and other mechanisms that are efficient and effective for purchasing services or goods on behalf of recipients.[3] Reimbursement is limited to claims for services provided for covered injuries or illnesses[4] by a provider who has a valid Medicaid provider agreement.[5] Since its inception in 1970, the program has paid nearly $300 billion to Medicaid providers of goods and services.[6]

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[1] The Federal Medical Assistance Percentages (FMAPs) are used to determine the amount of matching funds for state expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures. The regular average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum regular FMAP is 82%). *Financing & Reimbursement*, Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html; https://aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures (last viewed February 7, 2016).

[2] *Program Integrity*, Medicaid.gov https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html (last viewed on January 20, 2016).

[3] Section 409.908, F.S.

[4] "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance. S. 409.901(9), F.S.

[5] Section 409.907, F.S. Medicaid provider agreements are voluntary agreements between AHCA and a provider for the provision of services to Medicaid recipients and include background screening requirements, notification requirements for change of ownership, authority for AHCA site visits of provider service locations, and surety bond requirements.

[6] Agency for Health Care Administration and the Department of Legal Affairs, *The State's Efforts to Control Medicaid Fraud and Abuse, FY 2013-14*, December 15, 2015, page 34, available at http://ahca.myflorida.com/medicaid/recent_presentations/TheStatesEffortstoCombatMedicaidFraud2013-14.pdf (last viewed February 7, 2016).

AHCA's Office of Medicaid Program Integrity (MPI) and the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General are responsible for ensuring that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.[7]

MPI is statutorily required to develop statistical methodologies to identify providers who exhibit aberrant billing patterns.[8] MPI utilizes these methodologies to perform comprehensive audits and generalized analyses of Medicaid providers.[9] Overpayments identified through these audits are referred to AHCA's Division of Operations, Bureau of Financial Services (Financial Services) for collection.[10] Financial Services collects the overpayments through either direct payment or through withholding payment to the provider.[11]

Any suspected criminal violation identified by AHCA is referred to the MFCU. MFCU is responsible for investigating and prosecuting provider fraud within the Medicaid program which commonly involves fraud related to providers' billing practices, including billing for services that were not provided, overcharging for services that were provided and billing for services that were not medically necessary.[12] AHCA and MFCU are required to submit an annual joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year.[13]

Reimbursement of Medicaid Overpayment

Federal law requires the state to refund the federal share of any overpayment made to a Medicaid provider. An overpayment occurs when a Medicaid provider is paid in an amount in excess of the Medicaid established allowable amount for the service.[14] Overpayments can be discovered in a variety of ways, including audits performed by AHCA or CMS under their program integrity offices.[15] The state has one year from the date that AHCA or CMS discover an overpayment to recover or seek to recover the overpayment.[16] After one year, the state must refund the federal share of the overpayment, regardless of whether AHCA has actually recovered payment from the provider.[17]

Federal law also provides an exception to the mandatory federal share repayment provision. Audits are not always performed contemporaneously with payment and may occur several years after the overpayment to the Medicaid provider. Sometimes, the provider has gone out of business prior to the discovery of the overpayment. A state is not required to refund the federal portion of the overpayment if the provider is out of business on the date of discovery of the overpayment or if the provider goes out of business before the end of the one year period following discovery.[18] To prove the provider is out of business, a state must:[19]

- Document its efforts to locate the party and its assets;[20] and

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[7] Section 409.913, F.S.
[8] Id.
[9] Agency for Health Care Administration and the Department of Legal Affairs, *The State's Efforts to Control Medicaid Fraud and Abuse, FY 2014-15*, December 15, 2015, available at https://ahca.myflorida.com/Executive/Inspector_General/docs/Medicaid_Fraud_Abuse_Annual_Reports/2014-15_MedicaidFraudandAbuseAnnualReport.pdf (last viewed February 7, 2016).
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] 42 C.F.R. 433.304
[15] Section 409.913, F.S.; Section 1936 of the Social Security Act.
[16] 42 C.F.R. 433.312(a)(1).
[17] 42 C.F.R. 433.312(a)(2).
[18] 42 C.F.R. 433.318(d)(1).
[19] 42 C.F.R. 433.318(d)(2)(i) and (ii).
[20] These efforts must be consistent with applicable state policies and procedures.

- Provide an affidavit or certification from the appropriate state legal authority establishing that the provider is out of business and that the overpayment cannot be collected under state law and procedures, and citing the effective date of that determination.

Florida is currently required to repay the federal share of an overpayment when a provider is out business. No state law provision authorizes AHCA to certify that a provider is out of business and that the overpayment cannot be collected, so the federal exemption from mandatory repayment does not apply in Florida. As a result, Florida refunded the federal government $7.3 million in FY 2011-12, $1.5 million in FY 2012-13 and $2.8 million in FY 2013-14 for the federal share of Medicaid provider overpayments that it would not have had to refund if Florida had such a statutory provision.[21]

Effect of Proposed Changes

HB 1245 authorizes AHCA to certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law and procedures. This allows Florida to qualify for the exemption from mandatory federal share repayment for Medicaid provider overpayments, and retain those funds.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 2: Reenacts s. 409.8132, F.S., relating to Medikids program component.
Section 3: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Florida refunded to the federal government $7.3 million in FY 2011-12, $1.5 million in FY 2012-13 and $2.8 million in FY 2013-14 for the federal share of Medicaid provider overpayments. The bill permits AHCA to certify that a provider is out-of-business and that overpayments cannot be collected. As a result, Florida will not have to refund the federal share of future Medicaid overpayments to providers who are certified as out-of-business, which AHCA estimates will total between $1 and $3 million per fiscal year.[22]

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

[21] Agency for Health Care Administration, *2016 Agency Legislative Bill Analysis for HB 1245*, January 23, 2016 (on file with the Health and Human Services Committee staff).
[22] Id.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Medicaid provider overpayments; amending s. 409.908, F.S.; authorizing the Agency for Health Care Administration to certify that a Medicaid provider is out of business and that overpayments made to a provider cannot be collected under state law; reenacting s. 409.8132(4), F.S., relating to the applicability of certain laws to the Medikids program, to incorporate the amendment made by the act to s. 409.908, F.S., in a reference thereto; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (25) is added to section 409.908, Florida Statutes, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based

on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(25) In accordance with 42 C.F.R. s. 433.318(d), the agency may certify that a Medicaid provider is out of business and that any overpayments made to the provider cannot be collected under state law and procedures.

Section 2. For the purpose of incorporating the amendment made by this act to section 409.908, Florida Statutes, in a reference thereto, subsection (4) of section 409.8132, Florida Statutes, is reenacted to read:

409.8132 Medikids program component.—

(4) APPLICABILITY OF LAWS RELATING TO MEDICAID.—The provisions of ss. 409.902, 409.905, 409.906, 409.907, 409.908, 409.912, 409.9121, 409.9122, 409.9123, 409.9124, 409.9127, 409.9128, 409.913, 409.916, 409.919, 409.920, and 409.9205 apply to the administration of the Medikids program component of the Florida Kidcare program, except that s. 409.9122 applies to Medikids as modified by the provisions of subsection (7).

Section 3. This act shall take effect July 1, 2016.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Peters offered the following:

Amendment (with title amendment)

Between lines 48 and 49, insert:

Section 2. Section 409.9132, Florida Statutes, is amended to read:

409.9132 Pilot project to monitor home health services.—The Agency for Health Care Administration shall expand the home health agency monitoring pilot project in Miami-Dade County on a statewide basis effective July 1, 2012, except in counties in which the program is not cost-effective, as determined by the agency. The agency shall contract with a vendor to verify the utilization and delivery of home health services and provide an electronic billing interface for home health services. The contract must require the creation of a program to submit claims

electronically for the delivery of home health services. The program must verify ~~telephonically~~ visits for the delivery of home health services by using technology that is effective for identifying delivery of the home health services and deterring fraudulent or abusive billing for these services ~~voice biometrics~~. The agency may seek amendments to the Medicaid state plan and waivers of federal laws, as necessary, to implement or expand the pilot project. Notwithstanding s. 287.057(3)(e), the agency must award the contract through the competitive solicitation process and may use the current contract to expand the home health agency monitoring pilot project to include additional counties as authorized under this section.

T I T L E A M E N D M E N T

Between lines 6 and 7, insert:

amending s. 409.9132, F.S.; revising the manner in which the Medicaid program verifies a vendor's visits for the delivery of home health services;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1313 Low-THC Cannabis
SPONSOR(S): Brodeur
TIED BILLS: None **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	O'Callaghan	O'Callaghan
2) Health Care Appropriations Subcommittee	12 Y, 0 N	Pridgeon	Pridgeon
3) Health & Human Services Committee		O'Callaghan MK	Calamas TC

SUMMARY ANALYSIS

In 2014, the Legislature enacted the Compassionate Medical Cannabis Act (CMCA) to authorize dispensing organizations approved by the Department of Health (DOH) to manufacture, possess, sell, and dispense low-THC cannabis for medical use by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms. A physician may only order low-THC cannabis for medical use if the patient is a permanent resident of Florida, no other satisfactory alternative treatment option exists, the physician has determined that the risks of ordering the low-THC cannabis are reasonable in light of the potential benefit for the patient, and the physician has obtained voluntary informed consent to such treatment.

Under the CMCA, an applicant for approval as a dispensing organization has to meet certain criteria to be selected by DOH and DOH may select only five dispensing organizations in the state to grow, process, and dispense low-THC cannabis. Although there is specific criteria that must be met before DOH may approve an applicant as a dispensing organization, the CMCA does not include regulatory standards for the operation, security, and safety of dispensing organizations or the growing, processing, testing, packaging, labeling, dispensing, or transportation of low-THC cannabis.

The bill creates new regulatory standards for dispensing organizations, including standards for the growing, processing, testing, packaging, labeling, dispensing, and transportation of low-THC cannabis. The bill also provides DOH with greater regulatory oversight by authorizing DOH to perform inspections, create a patient and caregiver registration card system, assess fees and take disciplinary action, and create standards for laboratories testing low-THC cannabis.

The bill also increases the criteria a physician must meet to be eligible to order low-THC cannabis for a patient by requiring the physician to specialize in certain practice areas and specifying the length of time the physician must have treated the patient. The bill also limits a physician's order to a 30-day supply of low-THC cannabis. The bill prohibits a physician ordering low-THC cannabis from being employed by a dispensing organization and authorizes the appropriate regulatory board to take disciplinary action against a physician who orders low-THC cannabis and receives compensation from a dispensing organization related to the order.

The bill has an indeterminate negative fiscal impact on DOH; however DOH has authority to impose fees sufficient to cover the cost of the regulation of the program. There is no fiscal impact on local governments.

The bill has an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Marijuana, also called cannabis, has been used for a variety of health conditions for at least 3,000 years.[1] Currently, the U.S. Food and Drug Administration (FDA) hasn't approved the use of cannabis to treat any health condition due to the lack of research to show that the benefits of using cannabis outweigh the risks.[2] However, based on the scientific study of cannabinoids, which are chemicals contained in cannabis, the FDA has approved two synthetic prescription drugs that contain certain cannabinoids.[3]

Although there are more than 100 cannabinoids in a marijuana plant, the two main cannabinoids of medical interest are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is a mind-altering chemical that increases appetite and reduces nausea and may also decrease pain, inflammation, and muscle control problems. CBD is a chemical that does not affect the mind or behavior, but may be useful in reducing pain and inflammation, controlling epileptic seizures, and possibly treating mental illness and addictions.[4]

Research on the Medical Use of Cannabis

During the course of drug development, a typical compound is found to have some medical benefit and then extensive tests are undertaken to determine its safety and proper dosage for medical use.[5] In contrast, marijuana has been widely used in the United States for decades. In 2014, just over 49% of the U.S. population over 12 years old had tried marijuana or hashish at least once and just over 10% were current users.[6] The data on the adverse effects of marijuana are more extensive than the data on its effectiveness.[7] Clinical studies of marijuana are difficult to conduct as researchers interested in clinical studies of marijuana face a series of barriers, research funds are limited, and there is a daunting thicket of federal and state regulations to be negotiated.[8] In fact, recently, there has been an exponential rise in the use of marijuana compared to the rise in scientific knowledge of its benefits or adverse effects because some states have allowed the public or patients to access marijuana while the federal government continues to limit scientific and clinical investigators' access to marijuana for research.[9]

In 1999, the Institute of Medicine published a study based on a comprehensive review of existing scientific data and clinical studies pertaining to the medical value of marijuana.[10] The study concluded that there is potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of

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[1] U.S. Department of Health & Human Services, National Center for Complementary and Integrative Health, *Medical Marijuana*, *available at* https://nccih.nih.gov/health/marijuana (last visited on December 27, 2015).
[2] U.S. Department of Health & Human Services, National Center for Complementary and Integrative Health, *What is medical marijuana?*, *available at* http://www.drugabuse.gov/publications/drugfacts/marijuana-medicine (last visited on December 27, 2015).
[3] *Id.*
[4] *Id.*
[5] Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base*, The National Academies Press, 1999, available at http://www.nap.edu/catalog/6376/marijuana-and-medicine-assessing-the-science-base (last visited on December 27, 2015).
[6] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables*, *available at* http://www.samhsa.gov/data/population-data-nsduh/reports (last visited on December 27, 2015).
[7] *Supra* note 5 at 137.
[8] *Id.*
[9] Friedman, Daniel, M.D., Devinsky, Orrin, M.D., *Cannabinoids in the Treatment of Epilepsy*, NEW ENG. J. MED., September 10, 2015, on file with the Health Quality Subcommittee.
[10] *Supra* note 5 at 179.

nausea and vomiting, and appetite stimulation.[11] The study reports that smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances.[12]

The Institute of Medicine's study, which warned that smoking marijuana is harmful, was corroborated by a study published in the New England Journal of Medicine in 2014.[13] The 2014 study further warned that long-term marijuana use can lead to addiction and that adolescents have an increased vulnerability to adverse long-term outcomes from marijuana use.[14] Specifically, the study found that, as compared with persons who begin to use marijuana in adulthood, those who begin in adolescence are approximately 2 to 4 times as likely to have symptoms of cannabis dependence within 2 years after first use.[15] The study also found that cannabis-based treatment with THC may have irreversible effects on brain development in adolescents as the brain's endocannabinoid system undergoes development in childhood and adolescence.[16]

More recently, a study published in 2015 in the Journal of the American Medical Association found that there is moderate-quality evidence to support the use of cannabinoids for the treatment of chronic pain and spasticity and that there is low-quality evidence suggesting that cannabinoids are associated with improvements in nausea and vomiting due to chemotherapy, weight gain in HIV infection, sleep disorders, and Tourette syndrome.[17]

Despite the uncertainty of the efficacy of marijuana on various medical conditions, there has recently been much interest in the use of marijuana, especially the compound CBD, to treat epilepsy.[18] A few factors contributing to the interest of the public, media, and researchers in such treatment are that new anti-seizure drugs have not substantially reduced the proportion of patients with medically refractory seizures, the side effects of such drugs continue to have negative side effects to the central nervous system and affect quality of life, and there appears to be some evidence-based efficacy of such treatment based on case stories and limited preclinical and clinical studies.[19]

Federal Regulation of Cannabis

The Federal Controlled Substances Act[20] lists cannabis as a Schedule 1 drug, meaning it has a high potential for abuse, has no currently accepted medical use, and has a lack of accepted safety for use under medical supervision.[21] The Federal Controlled Substances Act imposes penalties on those who possess, sell, distribute, dispense, and use cannabis.[22] A first misdemeanor offense for possession of cannabis in any amount can result in a $1,000 fine and up to a year in prison, climbing for subsequent offenses to as much as $5,000 and three years.[23] Selling and cultivating cannabis are subject to even greater penalties.[24]

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[11] *Id.*
[12] *Id.*
[13] Volkow, N.D., Baler, R.D., Compton, W.M. and Weiss, S.R., *Adverse Health Effects of Marijuana Use*, NEW ENG. J. MED., June 5, 2014, *available at* dfaf.org/assets/docs/Adverse%20health%20effects.pdf (last visited on December 27, 2015).
[14] *Id.* at 2219.
[15] *Id.* at 2220.
[16] *Id.* at 2219.
[17] American Medical Association, *Cannabinoids for Medical Use: A Systematic Review and Meta-analysis*, JAMA, June 2015, on file with the Health Quality Subcommittee.
[18] *Supra* note 9 at 1048.
[19] *Supra* note 9 at 1048, 1052-1053, and 1056.
[20] 21 U.S.C. ss. 801-971.
[21] 21 U.S.C. s. 812.
[22] 21 U.S.C. ss. 841-65.
[23] 21 U.S.C. s. 844.
[24] 21 U.S.C. ss. 841-65.

In August of 2013, the United States Department of Justice (USDOJ) issued a publication entitled "Smart on Crime: Reforming the Criminal Justice System for the 21st Century."[25] This document details the federal government's changing stance on low-level drug crimes announcing a "change in Department of Justice charging policies so that certain people who have committed low-level, nonviolent drug offenses, who have no ties to large-scale organizations, gangs, or cartels will no longer be charged with offenses that impose draconian mandatory minimum sentences. Under the revised policy, these people would instead receive sentences better suited to their individual conduct rather than excessive prison terms more appropriate for violent criminals or drug kingpins."[26]

On August 29, 2013, United States Deputy Attorney General James Cole issued a memorandum to federal attorneys that appeared to relax the federal government's cannabis-related offense enforcement policies.[27] The memo stated that the USDOJ was committed to using its limited investigative and prosecutorial resources to address the most significant threats in the most effective, consistent, and rational ways, and outlined eight areas of enforcement priorities.[28] These enforcement priorities focused on offenses that would result in cannabis being distributed to minors, cannabis sale revenues going to criminal gangs or other similar organizations, and cannabis being grown on public lands.[29] The memo indicated that outside of the listed enforcement priorities, the federal government would not enforce federal cannabis-related laws in states that have legalized the drug and that have a robust regulatory scheme in place.[30]

In 2014, Congress enacted the Consolidated and Further Continuing Appropriations Act of 2015 (Appropriations Act of 2015). Section 538 of the Appropriations Act of 2015 prohibits the USDOJ from expending any funds in connection with the enforcement of any law that interferes with a state's ability to implement its own state law that authorizes the use, distribution, possession, or cultivation of medical marijuana.[31] Despite this prohibition in the Appropriations Act of 2015, the USDOJ has continued to take some enforcement measures against medical cannabis dispensaries. However, in October 2015, the United States District Court for the Northern District of California held that section 538 plainly on its face prohibits the Department of Justice from taking such action.[32] Congress recently re-enacted the prohibition in section 542 of the Consolidated Appropriations Act of 2016.[33]

Regulation of Cannabis in Other States

Currently, 23 states[34] and the District of Columbia have comprehensive laws that permit and regulate the use of cannabis for medicinal purposes.[35] While these laws vary widely, most specify the medical conditions a patient must be diagnosed with to be eligible to use cannabis for treatment, allow a caregiver to assist with such treatment, require the registration of the patient and caregiver and a

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[25] U.S. Department of Justice, *Smart on Crime: Reforming the Criminal Justice System for the 21st Century, available at* http://www.justice.gov/ag/smart-on-crime.pdf. (last visited on December 27, 2015).
[26] *Id.*
[27] U.S. Department of Justice, *Guidance Regarding Marijuana Enforcement*, August 29, 2014, *available at* http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf (last visited on December 27, 2015).
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] Pub. L. 113-235 (2014).
[32] *U.S. v. Marin Alliance for Medical Marijuana*, 2015 WL 6123062 (N.D. Cal. Oct. 19, 2015).
[33] Pub. L. 114-113 (2015).
[34] These states include: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington. California was the first to establish a medical marijuana program in 1996 and New York was the most recent state to pass medical marijuana legislation which took effect in July 2014. National Conference of State Legislatures, *State Medical Marijuana Laws, available at* http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx (last visited on December 27, 2015).
[35] According to the National Conference of State Legislatures, 17 other states allow the use of low-THC cannabis for medical use or allow a legal defense for such use, including Florida. National Conference of State Legislatures, *State Medical Marijuana Laws, available at* http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx (last visited on December 27, 2015).

registration ID card to be issued to the patient and caregiver, restrict where cannabis can be used, and provide standards pertaining to the growing, processing, packaging, transport, and dispensing of medical cannabis.

Patients' Use of Medical Cannabis

While nearly every state has a list of medical conditions for which the patient may be treated with medical cannabis, the particular conditions vary from state to state. Most states also provide a mechanism for the list of qualifying medical conditions to be expanded, usually by allowing a state agency or a board to add qualifying medical conditions to the list or by providing a physician with some discretion in determining whether such treatment would benefit the patient.[36] The most common qualifying conditions named[37] in the statutes of the states with comprehensive medical cannabis laws are:[38]

- Cancer- 22 states
- HIV/AIDS- 22 states
- Multiple sclerosis- 20 states
- Epilepsy- 20 states
- Glaucoma- 19 states
- Crohn's disease- 12 states
- Amyotrophic lateral sclerosis- 10 states
- Hepatitis C- 8 states
- Alzheimer's disease- 8 states

Most states require that at least one, but sometimes states require two, physicians to certify that the patient has a qualifying condition. Some states require physicians to have certain qualifications to be able to order medical cannabis for qualifying patients.[39] Qualifying patients are usually required to be registered in an electronic registry and must be issued a registration ID card, usually from a state agency.[40]

Most states place general restrictions on where medical cannabis may be used. Typically, medical cannabis may not be used in public places, such as parks and on buses, or in areas where there are more stringent restrictions placed on the use of drugs, such as in or around schools or in prisons.[41]

There are two general methods by which patients can obtain medical cannabis. They must either self-cultivate the cannabis in their homes, or buy cannabis from specified points of sale or dispensaries. Regulations governing the amount of medical cannabis that may be grown or dispensed varies widely. For example, the amount of medical cannabis patients are allowed to have ranges from 1 ounce of

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[36] For example, see the following state laws allowing an agency to approve other conditions: AS § 17.37.070 (Alaska), A.R.S. § 36-2801 (Arizona), C.R.S.A. Const. Art. 18, § 14 (Colorado), C.G.S.A. § 21a-408 (Connecticut), 16 Del.C. § 4902A (Delaware), HRS § 329-121 (Hawaii), 410 ILCS 130/10 (Illinois), M.C.L.A. 333.26423 (Michigan), M.S.A. §152.22 (Minnesota), N.R.S. 453A.050 (Nevada), N.H. Rev. Stat. §126-X:1 (New Hampshire), N.J.S.A. 24:6I-3 (New Jersey), N.M.S.A. 1978, § 26-2B-3 (New Mexico), O.R.S. § 475.302 (Oregon), and Gen. Laws 1956, § 21-28.6-3 (Rhode Island). For examples of states allowing for physician discretion in treating other conditions with medical cannabis, see M.G.L.A. 94C App. §1-2.

[37] These are diseases specified in states' statutes. The state statutes also included symptoms or conditions of diseases that could apply to several other diseases, such as cachexia or wasting syndrome, severe pain, severe nausea, seizures, or muscle spasms.

[38] Information based on research performed by Health Quality Subcommittee staff. The laws of each state are on file with the subcommittee.

[39] For example, the following states require the ordering physician to be a neurologist: Iowa (I.C.A. § 124D.3), Missouri (V.A.M.S. 192.945), Utah (U.C.A. 1953 § 26-56-103), and Wyoming (W.S.1977 § 35-7-1902). Additionally, Vermont requires a physician to establish a bona fide relationship with the patient for not less than 6 months before ordering such treatment. *See* 18 V.S.A. § 4472.

[40] *Supra* note 38.

[41] For example, see N.R.S. 453A.322 (Nevada), N.J.S.A. 18A:40-12.22 (New Jersey), 5 CCR 1006-2:12 (Colorado), and West's Ann.Cal.Health & Safety Code § 11362.768 (California).

usable[42] cannabis to 24 ounces of usable cannabis, depending on the state. Furthermore, the number of cannabis plants that patients are allowed to grow ranges from 2 mature marijuana plants to 18 seedling marijuana plants. At least 10 states limit the amount of medical cannabis that may be ordered by specifying the number of days or months of a supply a physician may order.[43]

Caregivers

Caregivers are generally allowed to purchase or grow cannabis for the patient, be in possession of a specified quantity of cannabis, and aid the patient in using cannabis, but are strictly prohibited from using cannabis themselves. Some states may also require the caregiver to be at least 21[44] and may prohibit the caregiver from being the patient's physician.[45] Like the patient receiving treatment, the caregiver is usually required to be registered and have a registration ID card, typically issued by a state agency.[46]

Quality and Safety Standards

States vary in their regulations of entities that grow, process, transport, and dispense medical cannabis. However, most states with comprehensive medical cannabis laws require such entities to meet certain standards to ensure the quality and safety of the medical cannabis and standards to ensure the security of the facilities possessing the medical cannabis. For example, some states require a state agency to establish and enforce standards for laboratory testing of medical cannabis.[47] States may also require certain packaging and labeling standards for medical cannabis, including the requirement for packaging to meet the standards under the United States Poison Prevention Packaging Act.[48] States' security measures may require facilities that grow, process, transport, and dispense medical cannabis to implement an inventory tracking system that tracks the cannabis from "seed-to-sale."[49]

Florida's Cannabis Laws

Criminal Law

Florida's drug control laws are set forth in ch. 893, F.S., entitled the Florida Comprehensive Drug Abuse Prevention and Control Act (Drug Control Act).[50] The Drug Control Act classifies controlled substances into five categories, ranging from Schedule I to Schedule V.[51] Cannabis is currently a Schedule I controlled substance,[52] which means it has a high potential for abuse, it has no currently accepted medical use in treatment in the United States, and its use under medical supervision does not meet accepted safety standards.[53] Cannabis is defined as:

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[42] "Usable cannabis" generally means the seeds, leaves, buds, and flowers of the cannabis plant and any mixture or preparation thereof, but does not include the stalks and roots of the plant or the weight of any non-cannabis ingredients combined with cannabis. For example, see 410 ILCS 130/10 (Illinois) and OAR 333-008-0010 (Oregon).

[43] *See* C.G.S.A. §21a-4089 (Connecticut), 410 ILCS 130/10 (Illinois), MD Code, Health-General, § 13-3301 (Maryland), M.G.L.A. 94C App. §1-2 (Massachusetts), M.S.A. § 152.29 (Minnesota), N.R.S. 453A.200 (Nevada), N.H. Rev. Stat. § 126-X:8 (New Hampshire), N.J.S.A. 24:6I-10 (New Jersey), N.M.S.A. 1978, § 26-2B-3 (New Mexico), and McKinney's Public Health Law § 3362 (New York).

[44] See, for example, 22 M.R.S.A. § 2423-A (Maine), 105 CMR 725.020 (Massachusetts), and Gen.Laws 1956, § 44-67-2 (Rhode Island).

[45] For an example of a law prohibiting a physician from being a caregiver, see the definition of "primary caregiver" in C.R.S.A. § 25-1.5-106 (Colorado).

[46] *Supra* note 38.

[47] *See* HRS § 329D-8 (Hawaii), N.R.S. 453A.368 (Nevada), and West's RCWA 69.50.348 (Washington).

[48] *See* C.R.S.A. § 12-43.3-104(Colorado) and Haw. Admin. Rules (HAR) § 11-850-92 (Hawaii).

[49] *See* C.R.S.A. § 35-61-105.5 (Colorado), OAR 333-064-0100 (Oregon), and West's RCWA 69.51A.250 (Washington- effective July 1, 2016).

[50] s. 893.01, F.S.

[51] s. 893.03, F.S.

[52] s. 893.03(1)(c)7., F.S.

[53] s. 893.03(1), F.S.

> All parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. The term does not include "low-THC cannabis," as defined in s. 381.986, if manufactured, possessed, sold, purchased, delivered, distributed, or dispensed, in conformance with s. 381.986.[54]

The Drug Control Act contains a variety of provisions criminalizing behavior related to cannabis:

- Section 893.13, F.S., makes it a crime to sell, manufacture, deliver, purchase, or possess cannabis. The penalties for these offenses range from first degree misdemeanors to second degree felonies.[55]
- Section 893.135(1)(a), F.S., makes it a first degree felony[56] to traffic in cannabis, i.e., to possess, sell, purchase, manufacture, deliver, or import more than 25 pounds of cannabis or 300 or more cannabis plants. Depending on the amount of cannabis or cannabis plants trafficked, mandatory minimum sentences of three to 15 years and fines of $25,000 to $200,000 apply to a conviction.[57]
- Section 893.147, F.S., makes it a crime to possess, use, deliver, manufacture, transport, or sell drug paraphernalia.[58] The penalties for these offenses range from first degree misdemeanors to second degree felonies.[59]

Medical Necessity Defense

Florida courts have held that persons charged with offenses based on the possession, use, or manufacture of marijuana may use the medical necessity defense, which requires a defendant to prove that:

- He or she did not intentionally bring about the circumstance which precipitated the unlawful act;
- He or she could not accomplish the same objective using a less offensive alternative; and
- The evil sought to be avoided was more heinous than the unlawful act.[60]

In *Jenks v. State,*[61] the defendants, a married couple, suffered from uncontrollable nausea due to AIDS treatment and had testimony from their physician that they could find no effective alternative treatment. The defendants tried cannabis, and after finding that it successfully treated their symptoms, decided to grow two cannabis plants.[62] They were subsequently charged with manufacturing and possession of drug paraphernalia. Under these facts, the First District Court of Appeal found that "section 893.03 does not preclude the defense of medical necessity" and that the defendants met the criteria for the medical necessity defense.[63] The court ordered the defendants to be acquitted.[64]

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[54] s. 893.02(3), F.S.

[55] A first degree misdemeanor is punishable by up to one year in county jail and a $1,000 fine; a third degree felony is punishable by up to five years imprisonment and a $5,000 fine; and a second degree felony is punishable by up to 15 years imprisonment and a $10,000 fine. ss. 775.082 and 775.083, F.S.

[56] A first degree felony is punishable by up to 30 years imprisonment and a $10,000 fine. ss. 775.082 and 775.083, F.S.

[57] s. 893.13(1)(a), F.S.

[58] Drug paraphernalia is defined in s. 893.145, F.S., as:

> All equipment, products, and materials of any kind which are used, intended for use, or designed for use in the planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, transporting, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of ch. 893, F.S., or s. 877.111, F.S.

[59] s. 893.147, F.S.

[60] *Jenks v. State*, 582 So.2d 676, 679 (Fla. 1st DCA 1991), *rev. denied,* 589 So.2d 292 (Fla. 1991).

[61] 582 So.2d 676 (Fla. 1st DCA 1991).

[62] *Id.*

[63] *Id.*

[64] *Id.*

Seven years after the *Jenks* decision, the First District Court of Appeal again recognized the medical necessity defense in *Sowell v. State*.[65] More recently, the State Attorney's Office in the Twelfth Judicial Circuit cited the medical necessity defense as the rationale for not prosecuting a person arrested for cultivating a small amount of cannabis in his home for his wife's medical use.[66]

Compassionate Medical Cannabis Act of 2014

The Compassionate Medical Cannabis Act of 2014[67] (CMCA) legalized a low tetrahydrocannabinol (THC) and high cannabidiol (CBD) form of cannabis (low-THC cannabis)[68] for the medical use[69] by patients suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms.

The CMCA provides that a Florida licensed allopathic or osteopathic physician who has completed certain training[70] and has examined and is treating such a patient may order low-THC cannabis for that patient to treat the disease, disorder, or condition or to alleviate its symptoms, if no other satisfactory alternative treatment options exist for the patient. To meet the requirements of the CMCA, each of the following conditions must be satisfied:

- The patient must be a permanent resident of Florida.
- The physician must determine that the risks of ordering low-THC cannabis are reasonable in light of the potential benefit for that patient.[71]
- The physician must register as the orderer of low-THC cannabis for the patient on the compassionate use registry (registry) maintained by the Department of Health (DOH) and must update the registry to reflect the contents of the order.
- The physician must maintain a patient treatment plan and must submit the plan quarterly to the University of Florida College of Pharmacy.
- The physician must obtain the voluntary informed consent of the patient or the patient's legal guardian to treatment with low-THC cannabis.[72]

Under the CMCA, DOH was required to approve five dispensing organizations by January 1, 2015, with one dispensing organization in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida. DOH was also authorized to impose an initial application and biennial renewal fee that is sufficient to cover the costs of regulating the program.[73] To be approved as a dispensing organization, an applicant must establish that it:

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[65] 739 So.2d 333 (Fla. 1st DCA 1998).

[66] *Interdepartmental Memorandum*, State Attorney's Office for the Twelfth Judicial Circuit of Florida, SAO Case # 13CF007016AM, April 2, 2013, on file with the Health Quality Subcommittee.

[67] *See* ch. 2014-157, L.O.F., and s. 381.986, F.S.

[68] The act defines "low-THC cannabis," as the dried flowers of the plant *Cannabis* which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight, or the seeds, resin, or any compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin. *See* s. 381.986(1)(b), F.S.

[69] Section 381.986(1)(c), F.S., defines "medical use" as "administration of the ordered amount of low-THC cannabis. The term does not include the possession, use, or administration by smoking. The term also does not include the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered or the qualified patient's legal representative on behalf of the qualified patient." Section 381.986(1)(e), F.S., defines "smoking" as "burning or igniting a substance and inhaling the smoke. Smoking does not include the use of a vaporizer."

[70] Section 381.986(4), F.S., requires such physicians to successfully complete an 8-hour course and examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association which encompasses the clinical indications for the appropriate use of low-THC cannabis, appropriate delivery mechanisms, contraindications for such use, and the state and federal laws governing its ordering, dispensing, and processing

[71] If a patient is younger than 18 years of age, a second physician must concur with this determination, and such determination must be documented in the patient's medical record. s. 381.986(2)(b), F.S.

[72] s. 381.986(2), F.S.

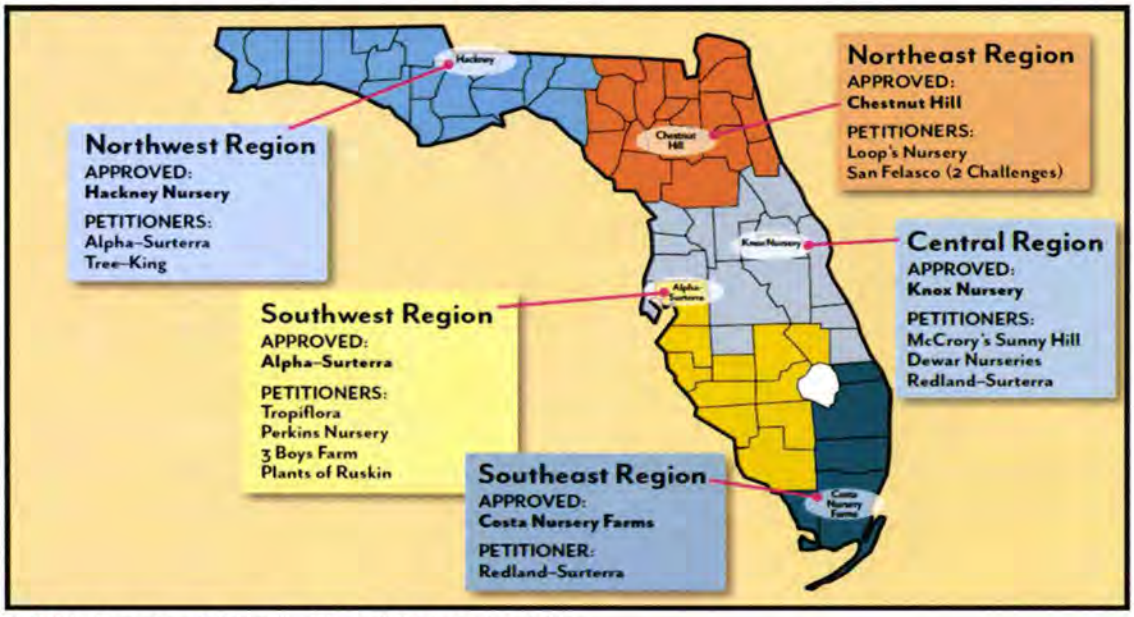
[73] s. 381.986(5)(b), F.S.

- Possesses a certificate of registration issued by the Department of Agriculture and Consumer Services for the cultivation of more than 400,000 plants;
- Is operated by a nurseryman;
- Has been operating as a registered nursery in this state for at least 30 continuous years;
- Has the technical and technological ability to cultivate and produce low-THC cannabis;
- Employs a medical director, who must be a physician and have successfully completed a course and examination that encompasses appropriate safety procedures and knowledge of low-THC cannabis; and
- Other specified requirements.[74]

Implementation by DOH of the dispensing organization approval process was delayed due to litigation challenging proposed rules that addressed the initial application requirements for dispensing organizations, revocation of dispensing organization approval, and inspection and cultivation authorization procedures for dispensing organizations. Such litigation was resolved on May 27, 2015, with an order entered by the Division of Administrative Hearings holding that the challenged rules do not constitute an invalid exercise of delegated legislative authority.[75] Thereafter, the rules took effect on June 17, 2015.[76]

The application process to become a dispensing organization closed on July 8, 2015, with 28 applications received by DOH. On November 23, 2015, DOH announced the five approved dispensing organizations: Hackney Nursery in the northwest region, Chestnut Hill Tree Farm in the northeast region, Knox Nursery in the central region, Costa Nursery Farms in the southeast region, and Alpha Foliage in the southwest region. To date, 13 petitions[77] have been filed contesting DOH's approval of these five dispensing organizations.[78]

APPROVED DISPENSING ORGANIZATIONS AND PENDING CHALLENGES



SOURCE: Department of Health, Office of Compassionate Use.

[74] *Id.*
[75] *Baywood v.Nurseries Co., Inc. v. Dep't of Health,* Case No. 15-1694RP (Fla. DOAH May 27, 2015).
[76] Rule Chapter 64-4, F.A.C.
[77] A copy of each petition is available at http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/ (last visited on December 28, 2015).
[78] Chestnut Hill Tree Farm also filed a counter-petition to San Felasco Nurseries' challenge to the Chestnut Hill Tree Farm being approved as the northeast region dispensing organization. *Chestnut Hill Tree Farm, LLC v. San Felasco Nurseries, Inc.*, Case. No. 15-007276, (Fla. DOAH, Dec. 18, 2015).

The CMCA provides that it is a first degree misdemeanor for:

- A physician to order low-THC cannabis for a patient without a reasonable belief that the patient is suffering from a required condition; or
- Any person to fraudulently represent that he or she has a required condition to a physician for the purpose of being ordered low-THC cannabis.[79]

The CMCA specifies that notwithstanding ss. 893.13, 893.135, or 893.147, F.S., or any other law that:

- Qualified patients[80] and their legal representatives may purchase and possess low-THC cannabis up to the amount ordered for the patient's medical use.
- Approved dispensing organizations and their owners, managers, and employees may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of reasonable quantities, as established by DOH rule, of low-THC cannabis. Such dispensing organizations and their owners, managers, and employees are not subject to licensure or regulation under ch. 465, F.S., relating to pharmacies.[81]

The CMCA requires DOH to create a secure, electronic, and online registry for the registration of physicians and patients.[82] Physicians must register as the orderer of low-THC cannabis for a named patient on the registry and must update the registry to reflect the contents of the order.[83] The registry must prevent an active registration of a patient by multiple physicians and must be accessible to law enforcement agencies and to a dispensing organization to verify patient authorization for low-THC cannabis and to record the low-THC cannabis dispensed.[84]

Effect of Proposed Changes

This bill creates additional regulatory standards under the Compassionate Medical Cannabis Act (CMCA) for dispensing organizations approved by DOH to grow, process, transport, and dispense low-THC cannabis. Additionally, the bill strengthens the criteria for physicians to be able to order low-THC cannabis, the criteria for physicians to become medical directors of dispensing organizations, and DOH's responsibilities under the CMCA. The bill includes other measures to increase the accountability of those who have access to low-THC cannabis, to increase the safety and quality of the low-THC cannabis being dispensed, and to increase the security of premises and personnel in possession of low-THC cannabis.

Dispensing Organizations

Current law requires approved dispensing organizations to maintain compliance with certain criteria required to be met prior to their selection, but it does not provide standards specifically relating to the quality or safety of low-THC cannabis or the security of entities possessing or transporting low-THC cannabis. The bill establishes new quality and safety standards for growing, processing, transporting and dispensing low-THC cannabis and security standards for those entities performing such acts.

[79] s. 381.986(3), F.S.
[80] Section 381.986(1)(d), F.S., provides that a "qualified patient" is a Florida resident who has been added by a physician licensed under ch. 458, F.S. or ch. 459, F.S., to the compassionate use registry to receive low-THC cannabis from a dispensing organization.
[81] s. 381.986(7), F.S.
[82] s. 381.985(5)(a), F.S.
[83] s. 381.986(2)(c), F.S.
[84] s. 381.985(5)(a), F.S.

Growing Low-THC Cannabis

When growing low-THC cannabis, the bill provides that a dispensing organization may use pesticides determined by DOH to be safely applied to plants intended for human consumption and requires the dispensing organization to:

- Grow and process low-THC cannabis within an enclosed structure and in a room separate from any other plant;
- Inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state, notify the Department of Agriculture and Consumer Services within 10 calendar days of a determination that a plant is infested or infected by such plant pest, and implement and maintain phytosanitary policies and procedures; and
- Perform fumigation or treatment of plants or the removal and destruction of infested or infected plants in accordance with ch. 581, F.S., or any rules adopted thereunder.

Processing Low-THC Cannabis

When processing low-THC cannabis, a dispensing organization must:

- Process the low-THC cannabis in an enclosure separate from other plants or products;
- Package the low-THC cannabis in compliance with the United States Poison Prevention Packaging Act (15 U.S.C. §§1471-1477);[85]
- Package the low-THC cannabis in a receptacle that has a firmly affixed and legible label stating the following information:
    - The name of the dispensing organization.
    - The quantity of low-THC cannabis contained within.
    - The cannabinoid profile of the low-THC cannabis, including the THC level.
    - Any ingredient other than low-THC cannabis contained within.
    - The date the low-THC is dispensed.
    - The patient's name and registration identification number.
    - A statement that the product is for medical use and not for resale or transfer to another person.
    - A unique serial number that will match the product with the original batch of low-THC cannabis from which the product was made to facilitate necessary warnings or recalls by DOH.
    - A recommended "use by" date or expiration date; and
- Reserve two processed samples per each batch, retain such samples for at least one year, and make those samples available for testing.

Dispensing Low-THC Cannabis

The bill prohibits a dispensing organization from dispensing more than a 30-day supply of low-THC cannabis to a patient or the patient's caregiver or selling any other type of retail product other than the physician ordered low-THC cannabis or paraphernalia. The bill also requires the dispensing organization to:

- Have the dispensing organization employee dispensing the low-THC cannabis enter into the compassionate use registry his or her name or unique employee identifier;

[85] The Poison Prevention Packaging Act requires packaging to be designed or constructed in a manner to make it significantly difficult for children under five years of age to open within a reasonable time, and not difficult for normal adults to use properly. *See* U.S. Consumer Product Safety Commission, *Poison Prevention Packaging Act, available at* http://www.cpsc.gov/en/Regulations-Laws--Standards/Statutes/Poison-Prevention-Packaging-Act/ (last visited on December 29, 2015).

- Verify in the compassionate use registry that a physician has ordered low-THC cannabis or a specific type of paraphernalia for the patient;
- Verify the patient or patient's caregiver holds a valid and active registration card; and
- Record in the compassionate use registry the paraphernalia dispensed, if any, in addition to the other information required under current law to be recorded in the registry.

Safety and Security Measures

The bill also requires the dispensing organization to implement and maintain certain safety and security measures relating to its facilities and certain safety and quality measures for low-THC cannabis dispensed or transported by the dispensing organization. Specifically, the bill requires the dispensing organization to:

- Maintain a fully operational security alarm system;
- Maintain a video surveillance system that records continuously 24 hours per day and meets specific minimum criteria;
- Retain video surveillance recordings for a minimum of 45 days, or longer upon the request of law enforcement;
- Enclose the perimeter of any buildings used in the cultivation, processing, or dispensing of low-THC cannabis with at least a six-foot high fence;
- Ensure that the outdoor premises of the dispensing organization has sufficient lighting from dusk until dawn;
- Dispense low-THC cannabis or paraphernalia only between the hours of 9 p.m. and 7 a.m., but allows the dispensing organization to perform all other operations 24 hours per day;
- Establish and maintain a tracking system approved by DOH that traces the low-THC cannabis from seed to sale, including key notification of events as determined by DOH;
- Store low-THC cannabis in secured, locked rooms or a vault;
- Have at least 2 employees of the dispensing organization or of a contracted security agency be on the dispensing organization premises at all times;
- Have all employees wear a photo identification badge at all times while on the premises;
- Have visitors wear a visitor's pass at all times while on the premises;
- Implement an alcohol and drug free workplace policy; and
- Report to local law enforcement within 24 hours of the dispensing organization being notified or becoming aware of the theft, diversion, or loss of low-THC cannabis.

To ensure the safe transport of low-THC cannabis to dispensing organization facilities, laboratories, or patients, the bill requires dispensing organizations to:

- Maintain a transportation manifest, which must be retained for at least one year;
- Ensure only vehicles in good-working order are used to transport low-THC cannabis;
- Lock low-THC cannabis in a separate compartment or container within the vehicle;
- Have at least two persons in a vehicle transporting low-THC cannabis and at least one person remain in the vehicle while the low-THC cannabis is being delivered; and
- Provide specific safety and security training to those employees transporting low-THC cannabis.

Physicians

Current law requires a physician to meet certain criteria, including additional training and education, to be qualified to order low-THC cannabis. The bill increases the qualification criteria and allows the physician to order paraphernalia for the administration of low-THC cannabis. "Paraphernalia" is defined by the bill as objects used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing low-THC cannabis into the human body. The additional criteria in the bill require the physician to:

- Be board-certified as an oncologist, neurologist, or epileptologist or specialize in the treatment of cancer, epilepsy, or physical medical conditions that chronically produce symptoms of seizures or severe and persistent muscle spasms. When treating a patient who is a minor and a second physician's concurrence for treatment using low-THC cannabis is required, the second physician must also meet this criterion.
- Have treated the patient for cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms for at least six months.
- Include in the registry the ordered amount of low-THC cannabis that will provide the patient with not more than a 30-day supply and any paraphernalia needed by the patient for the medical use of low-THC cannabis.

The bill prohibits a physician ordering low-THC cannabis from being employed as a medical director of a dispensing organization and provides that a physician who orders low-THC cannabis and receives compensation from a dispensing organization related to the ordering of low-THC cannabis may be subject to disciplinary action under the applicable practice act and under s. 456.072(1)(n), F.S.

The bill also increases the qualification criteria for medical directors of dispensing organizations by requiring the medical director to be board-certified as an oncologist, neurologist, or epileptologist or provide proof that he or she specializes in the treatment of cancer, epilepsy, or physical medical conditions that chronically produce symptoms of seizures or severe and persistent muscle spasms.

Testing Laboratories

Current law does not require the testing of low-THC cannabis by laboratories to ensure the composition of the low-THC cannabis to be dispensed complies with law or to ensure that it is safe. The bill requires a dispensing organization to contract with a laboratory approved by DOH for purposes of testing low-THC cannabis for compliance with the law and to detect any mold, bacteria, or other contaminant which may result in adverse effects to human health or the environment. The contract must require the laboratory to report to the dispensing organization, within 48 hours of a test, the cannabinoid composition of the product and whether the laboratory has detected any mold, bacteria, or other contaminant in the product which may result in adverse effects to human health or the environment.

The bill also creates an exemption from criminal law for DOH approved laboratories and their employees, allowing the laboratories and laboratory employees to possess, test, transport, and lawfully dispose of low-THC cannabis.

Department of Health

The bill grants DOH greater regulatory oversight of dispensing organizations by authorizing DOH to conduct inspections, set certain standards for laboratory testing of low-THC cannabis, establish a registration card system for patients and caregivers, and assess fines or take disciplinary action for certain violations. The bill also grants DOH authority to conduct additional acts to administer the CMCA. Specifically, the bill provides that DOH:

- May conduct announced or unannounced inspections of dispensing organizations to determine compliance with the law.
- Must inspect a dispensing organization upon complaint or notice provided to DOH that the dispensing organization has dispensed low-THC cannabis containing any mold, bacteria, or other contaminant that may cause or has caused an adverse effect to human health or the environment.
- Must conduct at least an annual inspection to evaluate dispensing organization records, personnel, equipment, processes, security measures, sanitation practices, and quality assurance practices.
- May inspect laboratories to ensure laboratories are using standardized procedures to test low-THC cannabis.

- May adopt standards for the approval of laboratories contracting with dispensing organizations, including standardized procedures, required equipment, and conflict of interest provisions.
- May enter into interagency agreements with the Department of Agriculture and Consumer Services, the Department of Business and Professional Regulation, the Department of Transportation, the Department of Highway Safety and Motor Vehicles, and the Agency for Health Care Administration, and such agencies are authorized to enter into an interagency agreement with DOH, to conduct inspections or perform other responsibilities assigned to DOH under the CMCA.
- Make a list of all approved dispensing organizations and qualified ordering physicians and medical directors publicly available on its website.
- May establish a system for issuing and renewing patient and caregiver registration cards, establish the circumstances under which the cards may be revoked by or must be returned to DOH, and establish fees to implement such system. DOH must require, at a minimum, the registration cards to:
    - State the name, address, and date of birth of the patient or caregiver.
    - Have a full-face, passport-style photograph of the patient or caregiver that has been taken within 90 days prior to registration.
    - Identify whether the cardholder is a patient or caregiver.
    - List a unique numerical identifier for the patient or caregiver that is matched to the identifier used for such person in DOH's compassionate use registry.
    - Provide the expiration date, which shall be from one year from the physician's initial order of low-THC cannabis.
    - For the caregiver, provide the name and unique numerical identifier of the patient the caregiver is assisting.
    - Be resistant to counterfeiting or tampering.
- Must create a schedule of violations in rule to impose reasonable fines not to exceed $10,000 on a licensee, and before assessing a fine must consider the severity of the violation, any actions taken by the licensee to correct the violation or to remedy complaints, and any previous violations.
- May suspend, revoke, or refuse to renew the license of a licensee for having a license, or the authority to practice any regulated profession or the authority to conduct any business, revoked, suspended, or otherwise acted against, including the denial of licensure by the licensing authority, for a violation that would constitute a violation under Florida law.
- May adopt rules necessary to implement the CMCA.

DOH is also responsible for overseeing a dispensing organization's advertising as the bill only allows a dispensing organization to use an insignia or logo approved by DOH.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1. Amends s. 381.986, F.S., relating to compassionate use of low-THC cannabis.
Section 2. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Section 381.986, F.S., authorizes DOH to impose an initial application and biennial renewal fee that is sufficient to cover the costs of administering the CMCA. This bill also authorizes DOH to establish fees to implement the registration card system should DOH create such a system. DOH estimates that the patient fees associated with the registry card system will be $30 per patient and

estimates that, initially, the patient pool applying for such cards will be approximately 10,000 to 20,000 patients.[86]

DOH may also generate revenue from any fines assessed against dispensing organizations in violation of the CMCA, which would also positively affect revenues.

2. Expenditures:

The DOH will incur costs associated with the regulatory standards for the operation, security, and safety of dispensing organizations or the growing, processing, testing, packaging, labeling, dispensing, or transportation of low-THC cannabis. DOH estimates that it will incur approximately $110,000 to $120,000 in costs associated with performing inspections and will require 1 full-time equivalent (FTE)[87] and 1 OPS related to the inspections.[88] These costs will be offset by the initial application and biennial renewal fees collected under s. 381.986, F.S.

DOH will also incur expenditures associated with implementation of the registration card system; however implementation of this system is permissive and the bill authorizes DOH to establish fees to implement the system. DOH has estimated that creation and implementation of the system will cost between $350,000 and $400,000.[89] Those expenses are related to printing cards, implementing anti-counterfeiting measures, establishing a HIPAA compliant card monitoring system, providing system security, and training and paying registry system personnel.[90]

DOH may also incur minimal costs associated with rulemaking and may incur significant costs associated with litigating rule challenges.[91] DOH estimates that, to retain outside counsel to defend against such challenges, it could incur costs of up to $600,000.[92]

DOH may also incur costs of approximately $65,000 to $110,000 associated with altering the existing statewide registry to include information required under the bill.[93]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

The bill does not appear to have any impact on local government revenues.

2. Expenditures:

The bill does not appear to have any impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Dispensing organizations may incur costs associated with meeting the bill's new quality, safety, and security standards unless they already meet such standards. Dispensing organizations will also incur costs associated with contracting with testing laboratories. The contract cost is indeterminate and may vary within each dispensing organization.

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[86] Department of Health, *2016 Agency Legislative Bill Analysis for HB 1313*, January 22, 2016, on file with the Health Quality Subcommittee.
[87] The FTE would be an Environmental Specialist II, which would cost DOH approximately $73,859, including salary, fringe benefits, travel, and other expenses. *Id.*
[88] *Supra* note 86.
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] *Id.*

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH appears to have sufficient rulemaking authority to carry out its responsibilities under the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to low-THC cannabis for medical use; amending s. 381.986, F.S.; providing and revising definitions; revising requirements for physicians ordering low-THC cannabis; providing that a physician who orders low-THC cannabis and receives related compensation from a dispensing organization is subject to disciplinary action; revising requirements relating to physician education; requiring the Department of Health to include caregiver information in the online compassionate use registry; revising requirements for dispensing organizations; specifying duties and responsibilities of the department; authorizing an approved laboratory and its employees to possess, test, transport, and lawfully dispose of low-THC cannabis or paraphernalia in certain circumstances; exempting an approved dispensing organization and related persons from the Florida Drug and Cosmetic Act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.986, Florida Statutes, is amended to read:

381.986 Compassionate use of low-THC cannabis.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Caregiver" means an individual who is 21 years of age or older, a permanent resident of the state, and registered with the department to assist a patient with the medical use of low-THC cannabis.

(b) ~~(a)~~ "Dispensing organization" means an organization approved by the department to cultivate, process, and dispense low-THC cannabis pursuant to this section.

(c) ~~(b)~~ "Low-THC cannabis" means a plant of the genus Cannabis, the dried flowers of which contain 0.8 percent or less of tetrahydrocannabinol and more than 10 percent of cannabidiol weight for weight; the seeds thereof; the resin extracted from any part of such plant; or any compound, manufacture, salt, derivative, mixture, or preparation of such plant or its seeds or resin that is dispensed only from a dispensing organization.

(d) ~~(c)~~ "Medical use" means administration of the ordered amount of low-THC cannabis. The term does not include the possession, use, or administration by smoking. The term also does not include the transfer of low-THC cannabis to a person other than the qualified patient for whom it was ordered, ~~or~~ the qualified patient's legal guardian if the guardian is a registered caregiver, or other registered caregiver ~~representative~~ on behalf of the qualified patient.

(e) "Paraphernalia" means objects used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing low-THC cannabis into the human body.

(f) ~~(d)~~ "Qualified patient" means a permanent resident of

this state who has been added to the compassionate use registry by a physician licensed under chapter 458 or chapter 459 to receive low-THC cannabis from a dispensing organization.

(g) ~~(e)~~ "Smoking" means burning or igniting a substance and inhaling the smoke. Smoking does not include the use of a vaporizer.

(2) PHYSICIAN ORDERING. ~~Effective January 1, 2015,~~ A physician is authorized to ~~licensed under chapter 458 or chapter 459 who has examined and is treating a patient suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms may~~ order ~~for the patient's medical use~~ low-THC cannabis to treat a patient suffering from cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms; ~~such disease, disorder, or condition or to~~ order low-THC cannabis to alleviate symptoms of such disease, disorder, or condition, if no other satisfactory alternative treatment options exist for the ~~that~~ patient; or order paraphernalia for the medical use of low-THC cannabis, only if the physician ~~and all of the following conditions apply~~:

(a) Holds an active, unrestricted license as a physician under chapter 458 or an osteopathic physician under chapter 459;

(b) Is board-certified as an oncologist, neurologist, or epileptologist or specializes in the treatment of cancer, epilepsy, or physical medical conditions that chronically produce symptoms of seizures or severe and persistent muscle

spasms;

(c) Has treated the patient for cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms for at least 3 months immediately preceding the patient's registration in the compassionate use registry;

(d) Has successfully completed the course and examination required under paragraph (4)(a);

(e) ~~(b)~~ Has determined ~~The physician determines~~ that the risks of treating the patient with ~~ordering~~ low-THC cannabis are reasonable in light of the potential benefit to the ~~for that~~ patient. If a patient is younger than 18 years of age, a second physician having a board certification or specialization described in paragraph (b) must concur with this determination, and such determination must be documented in the patient's medical record; ~~.~~

(f) ~~(c) The physician~~ Registers as the orderer of low-THC cannabis for the named patient on the compassionate use registry maintained by the department and updates the registry to reflect the contents of the order, including the amount of low-THC cannabis that will provide the patient with not more than a 30-day supply and any paraphernalia needed by the patient for the medical use of low-THC cannabis. The physician must also update the registry within 7 days after any change is made to the original order to reflect the change. The physician shall deactivate the patient's and caregiver's registration when

treatment is discontinued;~~.~~

(g)~~(d) The physician~~ Maintains a patient treatment plan that includes the dose, route of administration, planned duration, and monitoring of the patient's symptoms and other indicators of tolerance or reaction to the low-THC cannabis;~~.~~

(h)~~(e) The physician~~ Submits the patient treatment plan quarterly to the University of Florida College of Pharmacy for research on the safety and efficacy of low-THC cannabis on patients;~~.~~

(i)~~(f) The physician~~ Obtains the voluntary informed consent of the patient or the patient's legal guardian to treatment with low-THC cannabis after sufficiently explaining the current state of knowledge in the medical community of the effectiveness of treatment of the patient's condition with low-THC cannabis, the medically acceptable alternatives, and the potential risks and side effects; and

(j) Is not a medical director employed by a dispensing organization.

~~(a) The patient is a permanent resident of this state.~~

(3) PENALTIES.—

(a) A physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, if the physician orders low-THC cannabis or paraphernalia for a patient without a reasonable belief that the patient is suffering from:

1. Cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle

spasms that can be treated with low-THC cannabis; or

2. Symptoms of cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms that can be alleviated with low-THC cannabis.

(b) Any person who fraudulently represents that he or she has cancer or a physical medical condition that chronically produces symptoms of seizures or severe and persistent muscle spasms to a physician for the purpose of being ordered low-THC cannabis or paraphernalia by such physician commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) A physician who orders low-THC cannabis or paraphernalia and receives compensation from a dispensing organization related to the ordering of low-THC cannabis is subject to disciplinary action under the applicable practice act and s. 456.072(1)(n).

(4) PHYSICIAN EDUCATION.—

(a) Before ordering low-THC cannabis or paraphernalia for medical use by a patient in this state, the appropriate board shall require the ordering physician ~~licensed under chapter 458 or chapter 459~~ to successfully complete an 8-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses the clinical indications for the appropriate use of low-THC cannabis, the appropriate delivery mechanisms, the

contraindications for such use, as well as the relevant state and federal laws governing the ordering, dispensing, and possessing of this substance. The ~~first~~ course and examination shall ~~be presented by October 1, 2014, and shall~~ be administered at least annually ~~thereafter~~. Successful completion of the course may be used by a physician to satisfy 8 hours of the continuing medical education requirements required by his or her respective board for licensure renewal. This course may be offered in a distance learning format.

(b) The appropriate board shall require the medical director of each dispensing organization to hold an active, unrestricted license as a physician under chapter 458 or an osteopathic physician under chapter 459 and be board-certified as an oncologist, neurologist, or epileptologist or provide proof that he or she specializes in the treatment of cancer, epilepsy, or physical medical conditions that chronically produce symptoms of seizures or severe and persistent muscle spasms. Additionally, the medical director must ~~approved under subsection (5) to~~ successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses appropriate safety procedures and knowledge of low-THC cannabis.

(c) Successful completion of the course and examination specified in paragraph (a) is required for every physician who orders low-THC cannabis or paraphernalia each time such

physician renews his or her license. In addition, successful completion of the course and examination specified in paragraph (b) is required for the medical director of each dispensing organization each time such physician renews his or her license.

(d) A physician who fails to comply with this subsection and who orders low-THC cannabis or paraphernalia may be subject to disciplinary action under the applicable practice act and under s. 456.072(1)(k).

(5) DUTIES OF THE DEPARTMENT. ~~By January 1, 2015,~~ The department shall:

(a) Create and maintain a secure, electronic, and online compassionate use registry for the registration of physicians, ~~and~~ patients, and caregivers as provided under this section. The registry must be accessible to law enforcement agencies and to a dispensing organization ~~in order~~ to verify patient and caregiver authorization for low-THC cannabis and paraphernalia and record the low-THC cannabis and paraphernalia dispensed. The registry must prevent an active registration of a patient by multiple physicians.

(b) Authorize the establishment of five dispensing organizations to ensure reasonable statewide accessibility and availability as necessary for patients registered in the compassionate use registry and who are ordered low-THC cannabis or paraphernalia under this section, one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida. The

department shall develop an application form and impose an initial application and biennial renewal fee that is sufficient to cover the costs of administering this section. An applicant for approval as a dispensing organization must be able to demonstrate:

1. The technical and technological ability to cultivate and produce low-THC cannabis. The applicant must possess a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131 that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman as defined in s. 581.011, and have been operated as a registered nursery in this state for at least 30 continuous years.

2. The ability to secure the premises, resources, and personnel necessary to operate as a dispensing organization.

3. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

4. An infrastructure reasonably located to dispense low-THC cannabis to registered patients statewide or regionally as determined by the department.

5. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financials to the department. Upon approval, the applicant must post a $5 million performance bond.

6. That all owners and managers have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04.

7. The employment of a medical director who meets the qualifications of paragraph (4)(b) ~~is a physician licensed under chapter 458 or chapter 459~~ to supervise the activities of the dispensing organization.

(c) Monitor physician registration and ordering of low-THC cannabis or paraphernalia for ordering practices that could facilitate unlawful diversion or misuse of low-THC cannabis and take disciplinary action as indicated.

~~(d) Adopt rules necessary to implement this section.~~

(6) DISPENSING ORGANIZATION.—An approved dispensing organization, at all times, must ~~shall~~ maintain compliance with the criteria demonstrated for selection and approval as a dispensing organization under subsection (5) and the criteria required in this subsection ~~at all times~~.

(a) When growing low-THC cannabis, a dispensing organization:

1. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

2. Must grow and process low-THC cannabis within an enclosed structure and in a room separate from any other plant.

3. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state, notify the Department of Agriculture and Consumer Services within 10 calendar days after a determination that a plant is infested or infected by such plant pest, and implement and maintain phytosanitary policies and procedures.

4. Must perform fumigation or treatment of plants, or the removal and destruction of infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

(b) When processing low-THC cannabis, a dispensing organization must:

1. Process the low-THC cannabis in an enclosure separate from other plants or products.

2. Package the low-THC cannabis in compliance with the United States Poison Prevention Packaging Act, 15 U.S.C. ss. 1471-1477.

3. Package the low-THC cannabis in a receptacle that has a firmly affixed and legible label stating the following information:

a. The name of the dispensing organization.

b. The quantity of low-THC cannabis contained in the receptacle.

c. The cannabinoid profile of the low-THC cannabis, including the THC level.

d. Any ingredient other than low-THC cannabis contained in the receptacle.

e. The date that the low-THC is dispensed.

f. The patient's name and registration identification number.

g. A statement that the low-THC cannabis is for medical use and not for resale or transfer to another person.

h. A unique serial number corresponding to the original batch of low-THC cannabis from which the low-THC cannabis contained in the receptacle was made, to facilitate necessary warnings or recalls by the department.

i. A recommended "use by" date or expiration date.

4. Reserve two processed samples from each batch, retain such samples for at least 1 year, and make such samples available for testing.

(c) When dispensing low-THC cannabis or paraphernalia, a dispensing organization:

1. May not dispense more than a 30-day supply of low-THC cannabis to a patient or the patient's caregiver.

2. Must have the dispensing organization's employee who dispenses the low-THC cannabis or paraphernalia enter into the compassionate use registry his or her name or unique employee identifier.

3. Must verify in the compassionate use registry that a physician has ordered the low-THC cannabis or a specific type of paraphernalia for the patient.

4. May not dispense or sell any other type of retail product, other than physician-ordered paraphernalia, while

dispensing low-THC cannabis.

5. Must ~~Before dispensing low-THC cannabis to a qualified patient, the dispensing organization shall~~ verify that the patient has an active registration in the compassionate use registry, the patient or patient's caregiver holds a valid and active registration card, the order presented matches the order contents as recorded in the registry, and the order has not already been filled.

6. Must, upon dispensing the low-THC cannabis, ~~the dispensing organization shall~~ record in the registry the date, time, quantity, and form of low-THC cannabis and any paraphernalia dispensed.

(d) To ensure the safety and security of its premises and any off-site storage facilities, and to maintain adequate controls against the diversion, theft, and loss of low-THC cannabis, a dispensing organization must:

1. Maintain a fully operational security alarm system that secures all entry points and perimeter windows and is equipped with motion detectors; pressure switches; and duress, panic, and hold-up alarms.

2. Maintain a video surveillance system that records continuously 24 hours each day and meets the following minimum criteria:

a. Cameras are fixed in a place that allows for the clear identification of persons and activities in controlled areas of the premises. Controlled areas include grow rooms, processing

rooms, storage rooms, disposal rooms or areas, and point-of-sale rooms.

b. Cameras are fixed in entrances and exits to the premises, which shall record from both indoor and outdoor, or ingress and egress, vantage points.

c. Recorded images must clearly and accurately display the time and date.

3. Retain video surveillance recordings for a minimum of 45 days or longer upon the request of a law enforcement agency.

4. Enclose the perimeter of any buildings used in cultivating, processing, or dispensing low-THC cannabis with a fence or wall at least 6 feet in height.

5. Ensure that the organization's outdoor premises have sufficient lighting from dusk until dawn.

6. Establish and maintain a tracking system approved by the department that traces the low-THC cannabis from seed to sale. The tracking system shall include notification of key events as determined by the department, including when low-THC cannabis seeds are planted, low-THC cannabis plants are harvested, low-THC cannabis plants are destroyed, low-THC cannabis is transported, low-THC cannabis is sold, or a theft, diversion, or loss of low-THC cannabis occurs.

7. Not dispense low-THC cannabis or paraphernalia between the hours of 9 p.m. and 7 a.m., but may perform all other operations 24 hours each day.

8. Store low-THC cannabis in a secured, locked room or a

vault.

9. Require at least two of its employees, or two employees of a security agency with whom it contracts, to be on the organization's premises at all times.

10. Require each employee to wear a photo identification badge at all times while on the premises.

11. Require each visitor to wear a visitor's pass at all times while on the premises.

12. Implement an alcohol and drug-free workplace policy.

13. Report to local law enforcement within 24 hours after it is notified or becomes aware of the theft, diversion, or loss of low-THC cannabis.

(e) To ensure the safe transport of low-THC cannabis to dispensing organization facilities, laboratories, or patients, the dispensing organization must:

1. Maintain a transportation manifest, which must be retained for at least 1 year.

2. Ensure only vehicles in good working order are used to transport low-THC cannabis.

3. Lock low-THC cannabis in a separate compartment or container within the vehicle.

4. Require at least two persons to be in a vehicle transporting low-THC cannabis, and require at least one person to remain in the vehicle while the low-THC cannabis is being delivered.

5. Provide specific safety and security training to

employees transporting or delivering low-THC cannabis.

(f) A dispensing organization may only use an insignia or logo approved by the department to advertise its product.

(g) A dispensing organization must contract with a laboratory approved by the department for purposes of testing low-THC cannabis for compliance with this section and to detect any mold, bacteria, or other contaminant in the product that may result in adverse effects to human health or the environment. The contract must require the laboratory to report to the dispensing organization, within 48 hours after a test, the cannabinoid composition of the product and whether the laboratory has detected any mold, bacteria, or other contaminant in the product that may result in adverse effects to human health or the environment.

(7) DEPARTMENT AUTHORITY AND RESPONSIBILITIES.—

(a) The department:

1. May conduct announced or unannounced inspections of dispensing organizations to determine compliance with this section or rules adopted pursuant to this section.

2. Must inspect a dispensing organization upon complaint or notice provided to the department that the dispensing organization has dispensed low-THC cannabis containing any mold, bacteria, or other contaminant that may cause or has caused an adverse effect to human health or the environment.

3. Must conduct at least a biennial inspection of each dispensing organization to evaluate the dispensing

organization's records, personnel, equipment, processes, security measures, sanitation practices, and quality assurance practices.

(b) The department may inspect laboratories to ensure they are using standardized procedures to test low-THC cannabis.

(c) The department may adopt standards for the approval of laboratories contracting with dispensing organizations, including standardized procedures, required equipment, and conflict-of-interest provisions.

(d) The department may enter into interagency agreements with the Department of Agriculture and Consumer Services, the Department of Business and Professional Regulation, the Department of Transportation, the Department of Highway Safety and Motor Vehicles, and the Agency for Health Care Administration, and such agencies are authorized to enter into an interagency agreement with the department, to conduct inspections or perform other responsibilities assigned to the department under this section.

(e) The department must make a list of all approved dispensing organizations and qualified ordering physicians and medical directors publicly available on its website.

(f) The department may establish a system for issuing and renewing patient and caregiver registration cards, establish the circumstances under which the cards may be revoked by or must be returned to the department, and establish fees to implement such system. The department must require, at a minimum, the

registration cards to:

1. Provide the name, address, and date of birth of the patient or caregiver.

2. Have a full-face, passport-type, color photograph of the patient or caregiver taken within the 90 days immediately preceding registration.

3. Identify whether the cardholder is a patient or caregiver.

4. List a unique numeric identifier for the patient or caregiver that is matched to the identifier used for such person in the department's compassionate use registry.

5. Provide the expiration date, which shall be 1 year after the date of the physician's initial order of low-THC cannabis.

6. For the caregiver, provide the name and unique numeric identifier of the patient that the caregiver is assisting.

7. Be resistant to counterfeiting or tampering.

(g) The department must create a schedule of violations in rule to impose reasonable fines not to exceed $10,000 on a dispensing organization. In determining the amount of the fine to be levied for a violation, the department shall consider:

1. The severity of the violation.

2. Any actions taken by the dispensing organization to correct the violation or to remedy the complaint.

3. Any previous violations.

(h) The department may suspend, revoke, or refuse to renew

a dispensing organization's approval if the organization has had a license or authority to practice any regulated profession or the authority to conduct any business in any other state or country revoked, suspended, or otherwise acted against, including the denial of licensure by the licensing authority, for a violation that would constitute a violation under Florida law.

(i) The department may adopt rules necessary to implement this section.

(8) ~~(7)~~ EXCEPTIONS TO OTHER LAWS.—

(a) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, a qualified patient and the qualified patient's caregiver ~~legal representative~~ may purchase and possess for the patient's medical use up to the amount of low-THC cannabis ordered for the patient, but not more than a 30-day supply of low-THC cannabis.

(b) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an approved dispensing organization and its owners, managers, and employees may manufacture, possess, sell, deliver, distribute, dispense, and lawfully dispose of reasonable quantities, as established by department rule, of low-THC cannabis. For purposes of this subsection, the terms "manufacture," "possession," "deliver," "distribute," and "dispense" have the same meanings as provided in s. 893.02.

(c) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other provision of law, but subject to the requirements of this section, an approved laboratory and its employees may possess, test, transport, and lawfully dispose of low-THC cannabis or paraphernalia as provided by department rule.

(d) An approved dispensing organization and its owners, managers, and employees are not subject to licensure or regulation under chapter 465 or chapter 499 for manufacturing, possessing, selling, delivering, distributing, dispensing, or lawfully disposing of reasonable quantities, as established by department rule, of low-THC cannabis.

Section 2. This act shall take effect July 1, 2016.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Brodeur offered the following:

Amendment

Remove lines 166-241 and insert:

(b) The appropriate board shall require the medical director of each dispensing organization approved under subsection (5) to successfully complete a 2-hour course and subsequent examination offered by the Florida Medical Association or the Florida Osteopathic Medical Association that encompasses appropriate safety procedures and knowledge of low-THC cannabis. Any medical director hired by a dispensing organization after July 1, 2016, must successfully complete the course and examination required in this paragraph, must hold an active, unrestricted license as a physician under chapter 458 or chapter 459, and must be board-certified as an oncologist,

neurologist, or epileptologist or provide proof that he or she specializes in the treatment of cancer, epilepsy, or physical medical conditions that chronically produce symptoms of seizures or severe and persistent muscle spasms.

(c) Successful completion of the course and examination specified in paragraph (a) is required for every physician who orders low-THC cannabis or paraphernalia each time such physician renews his or her license. In addition, successful completion of the course and examination specified in paragraph (b) is required for the medical director of each dispensing organization each time such physician renews his or her license.

(d) A physician who fails to comply with this subsection and who orders low-THC cannabis or paraphernalia may be subject to disciplinary action under the applicable practice act and under s. 456.072(1)(k).

(5) DUTIES OF THE DEPARTMENT. ~~By January 1, 2015,~~ The department shall:

(a) Create and maintain a secure, electronic, and online compassionate use registry for the registration of physicians, ~~and~~ patients, and caregivers as provided under this section. The registry must be accessible to law enforcement agencies and to a dispensing organization ~~in order~~ to verify patient and caregiver authorization for low-THC cannabis and paraphernalia and record the low-THC cannabis and paraphernalia dispensed. The registry must prevent an active registration of a patient by multiple physicians.

(b) Authorize the establishment of five dispensing organizations to ensure reasonable statewide accessibility and availability as necessary for patients registered in the compassionate use registry and who are ordered low-THC cannabis or paraphernalia under this section, one in each of the following regions: northwest Florida, northeast Florida, central Florida, southeast Florida, and southwest Florida. The department shall develop an application form and impose an initial application and biennial renewal fee that is sufficient to cover the costs of administering this section. An applicant for approval as a dispensing organization must be able to demonstrate:

1. The technical and technological ability to cultivate and produce low-THC cannabis. The applicant must possess a valid certificate of registration issued by the Department of Agriculture and Consumer Services pursuant to s. 581.131 that is issued for the cultivation of more than 400,000 plants, be operated by a nurseryman as defined in s. 581.011, and have been operated as a registered nursery in this state for at least 30 continuous years.

2. The ability to secure the premises, resources, and personnel necessary to operate as a dispensing organization.

3. The ability to maintain accountability of all raw materials, finished products, and any byproducts to prevent diversion or unlawful access to or possession of these substances.

4. An infrastructure reasonably located to dispense low-THC cannabis to registered patients statewide or regionally as determined by the department.

5. The financial ability to maintain operations for the duration of the 2-year approval cycle, including the provision of certified financials to the department. Upon approval, the applicant must post a $5 million performance bond.

6. That all owners and managers have been fingerprinted and have successfully passed a level 2 background screening pursuant to s. 435.04.

7. The employment of a medical director who is a physician licensed under chapter 458 or chapter 459 to supervise the activities of the dispensing organization.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1313 (2016)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Brodeur offered the following:

Amendment

Remove lines 348-350

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1335 Long-term Care Prioritization
SPONSOR(S): Magar
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 2 N	Guzzo	Poche
2) Health Care Appropriations Subcommittee	12 Y, 0 N	Clark	Pridgeon
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

In 2011, the Legislature created the Statewide Medicaid Managed Care Program as an integrated managed care program for all covered services, including long-term care services. The Statewide Medicaid Managed Care Program consists of two programs: the Managed Medical Assistance Program (MMA Program) and the Long-Term Care Managed Care Program (LTC Program). The MMA Program covers primary and acute medical assistance and related services to Medicaid recipients.

The LTC Program provides services to Medicaid recipients in nursing facilities and in community settings, including an individual's home, an assisted living facility, or an adult family care home. To be eligible for the LTC Program, an individual must be:

- Age 65 or older and eligible for Medicaid, or age 18 or older and eligible for Medicaid by reason of a disability; and
- Determined to require nursing home care, or be at imminent risk of requiring nursing home care.

When an individual, or the individual's representative, expresses an interest in receiving LTC services, the Department of Elder Affairs (DOEA) screens and scores the individual based on his or her frailty and need for services. The individual is then placed on the waitlist for services. When funding is available, individuals are released from the waitlist based on their priority scores, which indicates their levels of frailty. The individual must be determined to be medically eligible for services by DOEA, and financially eligible for Medicaid by the Department of Children and Families (DCF), before they are approved to be enrolled in the LTC Program.

The process for prioritizing individuals to be placed on the waitlist, placing them on the waitlist, and releasing them from the waitlist for enrollment in the LTC Program is not currently addressed in statute or administrative rule.

HB 1335 establishes in statute the process DOEA uses to prioritize individuals for enrollment in the LTC Program. The process involves frailty-based screening, which results in a priority score that is used to place individuals on the waitlist. The bill requires DOEA to make the methodology used to calculate an individual's priority score publicly available on its website. The bill requires DOEA to rescreen individuals on the waitlist annually and provides for a rescreening due to a significant change in the individual's condition or circumstances. The bill establishes specific criteria for DOEA to terminate an individual from the waitlist. The bill exempts the following persons from the screening and waitlist process:

- Individuals age 18, 19, or 20, who have a chronic debilitating disease or conditions of one or more physiological or organ systems which make them dependent on 24-hour medical supervision;
- Individuals determined to be at high risk and referred by the adult protective services program within DCF; and
- Nursing facility residents who wish to transition into the community and who have resided in a skilled nursing facility licensed in Florida for at least 60 consecutive days.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Statewide Medicaid Managed Care

In 2010, the Florida House of Representatives contracted with a consultant to analyze Florida's Medicaid program and identify problems and possible solutions; the consultant concluded that Florida Medicaid's fragmented, complex system made it difficult to improve value for patients and taxpayers.[1] As a result, in 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S.

The SMMC program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[2] The SMMC program is administered by the Agency for Health Care Administration (AHCA) and is financed with federal and state funds.[3] Eligibility for the SMMC program is determined by the Department of Children and Families (DCF).[4]

Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees. The Long-Term Care Managed Care (LTC) Program provides services to frail elderly or disabled Medicaid recipients in nursing facilities and in community settings, including an individual's home, an assisted living facility, or an adult family care home.

Implementation of the LTC Program required approval by the federal Centers for Medicare and Medicaid Services (CMS) by virtue of 1915(b) and (c) waivers submitted by AHCA. The waivers were approved on February 1, 2013, and authorized the LTC Program to operate effective July 1, 2013, through June 30, 2016.[5] Initial enrollment into the LTC Program began August 1, 2013.

Long-Term Care Program

The LTC Program provides long term care services, including nursing facility and home and community based services, to eligible Medicaid recipients.

Federal law requires state Medicaid programs to provide nursing facility services to individuals, age 21 or older, and in need of nursing facility care.[6] Further, states are prohibited from limiting access to nursing facility services by establishing waiting lists.[7] Unlike nursing facility services, the provision of home and community based services is optional and there is a waitlist for receipt of these services.[8]

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[1] Medicaid Managed Care Study, Pacific Health Policy Group, p. 73, March 2010.
[2] This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.
[3] S. 409.963, F.S.
[4] Id.
[5] Letter from U.S. Department of Health and Human Services, Disabled and Elderly Health Programs Group to Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration (February 1, 2013), available at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last viewed February 4, 2016).
[6] 42 C.F.R. §483p(b).
[7] Medicaid.gov, *Nursing Facilities, Who May Receive Nursing Facility Services,* available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/institutional-care/nursing-facilities-nf.html (last viewed February 4, 2016).
[8] S. 409.906(13), F.S.

Home and community based services are delivered through a federal 1915(c), home and community based services waiver. Delivery of home and community based services to eligible recipients is dependent on the availability of annual funding. Enrollment in the home and community based services portion of the LTC Program is managed based on a priority system and waitlist. CMS approved 50,390 unduplicated recipients in the home and community based services portion of the LTC Program for FY 2015-16.[9]

As of January 1, 2016, there were 90,841 individuals enrolled in the LTC Program, including 50,390 individuals enrolled in the home and community based services portion of the LTC Program, and 40,451 individuals enrolled in the nursing facility services portion of the LTC Program.[10]

Long-term care plans are required to, at a minimum, cover the following:

- Nursing facility care;
- Services provided in assisted living facilities;
- Hospice;
- Adult day care;
- Medical equipment and supplies, including incontinence supplies;
- Personal care;
- Home accessibility adaptation;
- Behavior management;
- Home-delivered meals;
- Case Management;
- Occupation therapy;
- Speech therapy;
- Respiratory therapy;
- Physical therapy;
- Intermittent and skilled nursing;
- Medication administration;
- Medication Management;
- Nutritional assessment and risk reduction;
- Caregiver training;
- Respite care;
- Transportation; and
- Personal emergency response systems.[11]

To be eligible for the LTC Program, an individual must be:

- Age 65 or older and eligible for Medicaid, or age 18 or older and eligible for Medicaid by reason of a disability; and
- Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to require nursing facility care as defined in s. 409.985(3), F.S.[12]

When determining the need for nursing facility care, the nature of the services prescribed, the level of nursing or other health care personnel necessary to provide such services, and the availability of and

[9] Letter from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration (June 11, 2015), available at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/LTC_Waiver_Amend_Approval_Letter_2015-03-17.pdf (last viewed February 4, 2016).
[10] Agency for Health Care Administration, *SMMC LTC Enrollment by County/Plan Report* (as of January 1, 2016), available at http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml (last viewed February 4, 2016).
[11] S. 409.98, F.S.
[12] S. 409.979(1), F.S.

access to community or alternative resources are all considered.[13] For purposes of the LTC Program, "nursing facility care" means the individual requires, or is at imminent risk of:

- Nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional;
    - Also, the services are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual.
- Nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment;
    - Also, the services needed on a daily or intermittent basis are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically.
- Nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment.
    - Also, the necessary limited services are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.[14]

The Department of Elder Affairs (DOEA) administers programs and services for elders through 11 Area Agencies on Aging (AAAs), which also operate Aging and Disability Resource Centers (ADRCs). The ADRCs provide information and referral services to individuals seeking long-term care services. The ADRCs also screen individuals for eligibility for long-term care services.

The LTC Program enrollment process is administered by DOEA, DCF, and AHCA. An individual in need of services or seeking services must contact the appropriate ADRC to request a screening. The screening is intended to provide the ADRC with information describing the individual's level of frailty. During the screening, the ADRC gathers basic information about the individual, including general health information and any assistance the individual needs with activities of daily living. Based on the screening, the individual receives a priority score, which indicates the level of need for services and reflects the level of the individual's frailty. Using the priority score, the individual is then placed on the waitlist.

When funding becomes available, the frailest individuals are taken off the waitlist first, based upon priority score. The individual must then go through a comprehensive face-to-face assessment conducted by the local CARES staff.[15] After CARES determines the medical eligibility of the individual, DCF determines the financial eligibility of the individual. If approved for both medical and financial eligibility, AHCA must notify the individual and provide information on selecting a long-term care plan.

The process for prioritizing individuals to be placed on the waitlist, placing them on the waitlist, and releasing them from the waitlist for enrollment in the LTC Program is not currently addressed in statute or administrative rule.

To maintain the LTC Program and ensure the provision of services to those depending on them, the process DOEA uses to prioritize individuals in the LTC Program have been included within the General

[13] S. 409.985(3), F.S.
[14] S. 409.985(3), F.S.
[15] Florida Department of Elder Affairs, *Comprehensive Assessment and Review for Long-Term Care Services (CARES)*, available at: www.elderaffairs.state.fl.us/does/cares.php (last viewed February 4, 2016). Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants. A registered nurse or assessor performs client assessments. A physician or registered nurse reviews each application to determine the level of care that is most appropriate for the applicant. The assessment identifies long-term care needs, and establishes the appropriate level of care (medical eligibility for nursing facility care), and recommends the least restrictive, most appropriate placement. Federal law also mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement, or who seeks to receive home and community-based services through Medicaid waivers.

Appropriations Act Implementing Bill for the last two fiscal years (Chapter 2014-56 and Chapter 2015-222, Laws of Florida).

Effect of Proposed Changes

HB 1335 establishes in statute the process DOEA uses to prioritize individuals for enrollment in the LTC Program. The process involves frailty-based screening that provides a priority score that is used to place individuals on the waitlist. The screening must be conducted by a person certified by DOEA. The bill requires DOEA to make the methodology used to calculate an individual's priority score publicly available on its website. The bill requires DOEA to rescreen individuals on the waitlist annually and provides for a rescreening due to a significant change in the individual's condition or circumstances.

The bill authorizes DOEA to terminate an individual from the waitlist if he or she:

- Does not have a current priority score;
- Wishes to be removed from the waitlist;
- Does not keep an appointment to complete the rescreening without rescheduling beforehand;
- Is no longer eligible to receive services because he or she has not completed or met clinical or financial eligibility requirements;
- Begins the eligibility process for the LTC Program; or
- Begins receiving home and community-based services through the long-term care managed care program.

The bill provides that certain individuals have priority for enrollment in the LTC Program and are exempt from participating in the screening or waitlist process, including individuals:

- Age 18, 19, or 20, who have a chronic debilitating disease or conditions of one or more physiological or organ systems which make them dependent on 24-hour medical supervision;
- Determined to be at high risk and referred by the adult protective services program within DCF; and
- Nursing facility residents who wish to transition into the community and who have resided in a skilled nursing facility licensed in Florida for at least 60 consecutive days.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.962, F.S., relating to definitions.
Section 2: Amends s. 409.979, F.S., relating to eligibility.
Section 3: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The process DOEA uses to prioritize individuals in the LTC Program have been included within the General Appropriations Act Implementing Bill for the last two fiscal years (Chapter 2014-56 and Chapter 2015-222, Laws of Florida). This bill permanently codifies the process in statute.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

See Drafting Issues, Section III, c., below.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DOEA requires specific rulemaking authority to promulgate rules associated with the LTC Program enrollment process. The bill does not provide authority for DOEA to engage in the required rulemaking process.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to long-term care prioritization; amending s. 409.962, F.S.; defining terms; amending s. 409.979, F.S.; providing a process for waitlist prioritization and enrollment in the long-term care managed care program; requiring the Agency for Health Care Administration and the Department of Elderly Affairs to implement a screening and prioritization process; requiring the department to send written correspondence under certain circumstances; authorizing the department to terminate an individual from the waitlist under certain circumstances; requiring individuals to be financially and clinically eligible before enrollment in the program; providing exemptions from the screening or waitlist process; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.962, Florida Statutes, is amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(1) "Accountable care organization" means an entity qualified as an accountable care organization in accordance with federal regulations, and which meets the requirements of a

provider service network as described in s. 409.912(2).

(2) "Agency" means the Agency for Health Care Administration.

(3) "Aging network service provider" means a provider that participated in a home and community-based waiver administered by the Department of Elderly Affairs or the community care service system pursuant to s. 430.205 as of October 1, 2013.

(4) "APPL" means the assessed priority pipeline list, maintained by the Department of Elderly Affairs, which lists individuals who have been released from the waitlist for potential enrollment in the long-term care managed care program.

(5) "Authorized or designated representative" means an individual who has the legal authority to make decisions on behalf of a Medicaid enrollee or potential Medicaid enrollee in matters related to the screening process, the eligibility process, or the managed care plan.

(6) ~~(4)~~ "Comprehensive long-term care plan" means a managed care plan, including a Medicare Advantage Special Needs Plan organized as a preferred provider organization, provider-sponsored organization, health maintenance organization, or coordinated care plan, which ~~that~~ provides services described in s. 409.973 and also provides the services described in s. 409.98.

(7) ~~(5)~~ "Department" means the Department of Children and Families.

(8) ~~(6)~~ "Eligible plan" means a health insurer authorized

under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(2) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391 and entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

(9) ~~(7)~~ "Long-term care plan" means a managed care plan that provides the services described in s. 409.98 for the long-term care managed care program.

(10) ~~(8)~~ "Long-term care provider service network" means a provider service network a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

(11) ~~(9)~~ "Managed care plan" means an eligible plan under contract with the agency to provide services in the Medicaid program.

(12) ~~(10)~~ "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C.

ss. 1396 et seq., and regulations thereunder, as administered in this state by the agency.

(13) ~~(11)~~ "Medicaid recipient" or "recipient" means an individual who the department or, for Supplemental Security Income, the Social Security Administration determines is eligible pursuant to federal and state law to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(14) ~~(12)~~ "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(2), in the state and is paid a prospective per-member, per-month payment by the agency.

(15) "Priority score" means a number that indicates an individual's need for services and that is used to prioritize an individual's enrollment in the long-term care managed care program.

(16) ~~(13)~~ "Provider service network" means an entity qualified pursuant to s. 409.912(2) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed

health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

(17) "Rescreening" means the use of a screening tool by staff of the Department of Elderly Affairs to conduct a recurring annual screening of an individual or a screening due to a significant change in the individual's condition. The Department of Elderly Affairs shall conduct the annual screening within 13 months after the previous screening.

(18) "Screening" means the use of a screening tool by Department of Elderly Affairs staff for initial screenings, which must occur prior to placement on the waitlist.

(19) "Significant change in the individual's condition" means, in relation to screening or rescreening for long-term care services, a change in the individual's health status after an accident or illness; a change in his or her living situation; a change in his or her caregiver relationship; the loss, damage, or deterioration of his or her home environment; or the loss of his or her spouse or caregiver.

(20) ~~(14)~~ "Specialty plan" means a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

(21) "Waitlist" means the statewide assessed priority consumer list, maintained by the Department of Elderly Affairs, which lists in priority order individuals who have completed the scoring and placement process before enrollment in the home and

community-based services portion of the long-term care managed care program.

Section 2. Subsection (3) of section 409.979, Florida Statutes, is amended, and subsections (4) through (10) are added to that section, to read:

409.979 Eligibility.—

(3) The Department of Elderly Affairs shall prioritize individuals for enrollment in the long-term care managed care program using a frailty-based screening that provides a priority score that is used to place individuals on the waitlist. The Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on the assigned priority score ~~a wait-list prioritization~~ and subject to the availability of funds. Before making enrollment offers, the department must ~~shall~~ determine that sufficient funds exist to support additional enrollment into plans.

(4) The Department of Elderly Affairs shall maintain the waitlist, which is the only waitlist for the long-term care managed care program and, with the agency, may limit enrollment in the program so as not to exceed:

(a) The number of Medicaid recipients who may be enrolled, or who are projected to be enrolled, in the long-term care managed care program under the total long-term care managed care program allocation in the General Appropriations Act.

(b) The available funding to serve the total number of individuals on the APPL.

(5) A person certified by the Department of Elderly Affairs shall complete the screening for each individual requesting enrollment in the long-term care managed care program. The individual requesting long-term care services, or the individual's authorized or designated representative, must participate in an initial screening. The screening must be completed in its entirety before an individual may be placed on the waitlist for the program.

(6) The Department of Elderly Affairs shall generate a priority score upon completion of the screening, which shall be used to prioritize an individual's order of enrollment into the program. Upon completion of the scoring and waitlist placement process, the Department of Elderly Affairs shall provide the individual, or his or her authorized or designated representative, with notification of waitlist placement and shall make publicly available on its website the specific methodology used to calculate an individual's priority score. The individual, or his or her authorized or designated representative, may request a rescreening due to a significant change in the individual's condition. The Department of Elderly Affairs shall perform a rescreening annually so that an individual may remain on the waitlist.

(7) If the Department of Elderly Affairs is unable to contact the individual to schedule an initial screening, a significant change rescreening, or an annual rescreening, it shall send written correspondence to the last documented address

of the individual or to the authorized or designated representative listed for that individual. The written correspondence shall request that the individual contact the Department of Elderly Affairs within 10 business days after the date of the notice and notify the individual that he or she may be terminated from the screening process or waitlist due to the Department of Elderly Affairs' inability to successfully make contact and perform the screening or rescreening.

(8) The Department of Elderly Affairs may terminate an individual from the waitlist if he or she meets any of the following criteria:

(a) Does not have a current priority score.

(b) Wishes to be removed from the waitlist.

(c) Does not keep an appointment to complete the rescreening without rescheduling beforehand.

(d) Is no longer eligible to receive services because he or she has not completed or met clinical or financial eligibility requirements.

(e) Begins the eligibility process for the long-term care managed care program.

(f) Begins receiving home and community-based services through the long-term care managed care program.

(9) Before enrollment in the program, individuals must be determined financially and clinically eligible. The Department of Elderly Affairs shall determine clinical eligibility, and the Department of Children and Families shall determine financial

eligibility, for Medicaid pursuant to s. 409.919.

(10) The following individuals have priority for enrollment in the long-term care managed care program and are exempt from participating in the screening or waitlist process if all other program eligibility requirements are met:

(a) Individuals who are at least 18 years, but younger than 21 years, of age who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent on 24-hour-a-day medical, nursing, or health supervision or intervention.

(b) Individuals determined to be at high risk and referred by the adult protective services program within the Department of Children and Families.

(c) Nursing facility residents who wish to transition into the community and who have resided in a skilled nursing facility licensed in this state for at least 60 consecutive days.

Section 3. This act shall take effect July 1, 2016.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Magar offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Present subsections (4) through (13) of section 409.962, Florida Statutes, are redesignated as subsections (5) through (14), respectively, present subsection (14) of that section is redesignated as subsection (18), and new subsection (4) and subsections (15), (16), and (17) are added to that section to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(4) "Authorized representative" means an individual who has the legal authority to make decisions on behalf of a Medicaid recipient or potential Medicaid recipient in matters

related to the managed care plan or the screening or eligibility process.

(15) "Rescreening" means the use of a screening tool to conduct annual screenings or screenings due to a significant change which determine an individual's placement and continuation on the wait list.

(16) "Screening" means the use of an information-collection tool to determine a priority score for placement on the wait list.

(17) "Significant change" means change in an individual's health status after an accident or illness; an actual or anticipated change in the individual's living situation; a change in the caregiver relationship; loss of or damage to the individual's home or deterioration of his or her home environment; or loss of the individual's spouse or caregiver.

Section 2. Section 409.979, Florida Statutes, is amended to read:

409.979 Eligibility.—

(1) PREREQUISITE CRITERIA FOR ELIGIBILITY.-Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:

(a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.

(b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening Program ~~Program~~ to require nursing facility care as defined in s. 409.985(3).

(2) ENROLLMENT OFFERS.- ~~Medicaid recipients who, on the date long-term care managed care plans become available in their region, reside in a nursing home facility or are enrolled in one of the following long-term care Medicaid waiver programs are eligible to participate in the long-term care managed care program for up to 12 months without being reevaluated for their need for nursing facility care as defined in s. 409.985(3):~~

~~(a) The Assisted Living for the Frail Elderly Waiver.~~

~~(b) The Aged and Disabled Adult Waiver.~~

~~(c) The Consumer-Directed Care Plus Program as described in s. 409.221.~~

~~(d) The Program of All-inclusive Care for the Elderly.~~

~~(e) The Channeling Services Waiver for Frail Elders.~~

~~(3)~~ Subject to the availability of funds, the ~~The~~ Department of Elderly Affairs shall make offers for enrollment to eligible individuals based on a wait-list prioritization ~~and subject to availability of funds~~. Before making enrollment offers, the agency and the Department of Elderly Affairs ~~department~~ shall determine that sufficient funds exist to support additional enrollment into plans.

(3) WAIT LIST, RELEASE, AND OFFER PROCESS.-The Department of Elderly Affairs shall maintain a statewide wait list for

enrollment for home and community-based services through the long-term care managed care program.

(a) The Department of Elderly Affairs shall prioritize individuals for potential enrollment for home and community-based services through the long-term care managed care program using a frailty-based screening tool that results in a priority score. The priority score is used to set an order for releasing individuals from the wait list for potential enrollment in the long-term care managed care program. If capacity is limited for individuals with identical priority scores, the individual with the oldest date of placement on the waitlist shall receive priority for release.

1. Pursuant to s. 430.2053, Aging Resource Center personnel certified by the Department of Elderly Affairs shall perform the screening for each individual requesting enrollment for home and community-based services through the long-term care managed care program. The Department of Elderly Affairs shall request that the individual or the individual's authorized representative provide alternate contact names and contact information.

2. The individual requesting the long-term care services, or the individual's authorized representative, must participate in an initial screening or rescreening for placement on the wait list. The screening or rescreening must be completed in its entirety before placement on the wait list.

3. Pursuant to s. 430.2053, Aging Resource Center personnel shall administer rescreening annually or upon notification of a significant change in an individual's circumstances.

4. The Department of Elderly Affairs shall adopt by rule a screening tool that generates the priority score, and shall make publicly available on its website the specific methodology used to calculate an individual's priority score.

(b) Upon completion of the screening or rescreening process, the Department of Elderly Affairs shall notify the individual or the individual's authorized representative that the individual has been placed on the wait list.

(c) If the Department of Elderly Affairs is unable to contact the individual or the individual's authorized representative to schedule an initial screening or rescreening, and documents the actions taken to make such contact, it shall send a letter to the last documented address of the individual or the individual's authorized representative. The letter must advise the individual or his or her authorized representative that he or she must contact the Department of Elderly Affairs within 30 calendar days after the date of the notice to schedule a screening or rescreening and must notify the individual that failure to complete the screening or rescreening will result in his or her termination from the screening process and the wait list.

(d) After notification by the agency of available capacity, the CARES program shall conduct a prerelease assessment. The Department of Elderly Affairs shall release individuals from the wait list based on the priority scoring process and prerelease assessment results. Upon release, individuals who meet all eligibility criteria may enroll in the long-term care managed care program.

(e) The Department of Elderly Affairs may terminate an individual's inclusion on the wait list if the individual:

1. Does not have a current priority score due to the individual's action or inaction;

2. Requests to be removed from the wait list;

3. Does not keep an appointment to complete the rescreening without scheduling another appointment and has not responded to three documented attempts by the Department of Elderly Affairs to contact the individual;

4. Receives an offer to begin the eligibility determination process for the long-term care managed care program; or

5. Begins receiving services through the long-term care managed care program.

An individual whose inclusion on the wait list is terminated must initiate a new request for placement on the wait list, and any previous priority considerations must be disregarded.

(f) Notwithstanding this subsection, the following individuals are afforded priority enrollment for home and community-based services through the long-term care managed care program and do not have to complete the screening or wait-list process if all other long-term care managed care program eligibility requirements are met:

1. Individuals who are 18, 19, or 20 years of age who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make the individual dependent upon 24-hour-per-day medical, nursing, or health supervision or intervention.

2. Nursing facility residents requesting to transition into the community who have resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days.

3. Individuals referred by the Department of Children and Families Adult Protective Services as high risk and placed in an assisted living facility temporarily funded by the Department of Children and Families.

(g) The Department of Elderly Affairs and the agency may adopt rules to implement this subsection.

Section 3. This act shall take effect on July 1, 2016.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

An act relating to long-term care managed care prioritization; amending s. 409.962, F.S.; defining terms; amending s. 409.979, F.S.; requiring the Department Elderly Affairs to maintain a statewide wait list for enrollment for home and community-based services through the Medicaid long-term care managed care program; requiring the department to prioritize individuals for potential enrollment using a frailty-based screening tool that provides a priority score; providing for determinations regarding offers of enrollment; requiring screening and certain rescreening by Aging Resource Center personnel of individuals requesting long-term care services from the program; requiring the department to adopt by rule a screening tool; requiring the department to make a specified methodology available on its website; requiring the department to notify applicants if they are placed on the wait list; requiring the department to document its action steps to contact an individual to schedule a screening or rescreening; requiring the department to send a letter to an individual who it is unable to contact to schedule an initial screening or rescreening; requiring the department to conduct prerelease assessments upon notification by the agency of available capacity; authorizing certain individuals to enroll in the long-term care managed care program; authorizing the department to terminate an individual from the wait list under certain circumstances; providing for priority enrollment for home and community-based services for certain individuals;

authorizing the department and the Agency for Health Care Administration to adopt rules; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1411 Termination of Pregnancies
SPONSOR(S): Health Care Appropriations Subcommittee; Burton and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1722

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	7 Y, 6 N	McElroy	O'Callaghan
2) Health Care Appropriations Subcommittee	9 Y, 4 N, As CS	Pridgeon	Pridgeon
3) Health & Human Services Committee		McElroy CM	Calamas

SUMMARY ANALYSIS

CS/HB 1411 amends abortion clinic licensure requirements, prohibits the sale or donation of fetal remains, prohibits certain public funding, and creates a registration program for abortion referral and counseling agencies.

Abortion clinics are regulated by the Agency for Health Care Administration (AHCA) under ch. 390, F.S. The bill amends the regulatory requirements for abortion clinics. It establishes the manner for disposal of fetal remains and clarifies the penalty for failing to do so. It requires all abortion clinics to comply with the reporting requirements for the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention. It removes an existing license fee cap and requires AHCA to establish fees which may not be more than the costs incurred by AHCA in licensing and regulating abortion clinics.

The bill requires abortion clinics that perform abortions after the first trimester to have a written transfer agreement with a hospital within a reasonable proximity to the clinic, and requires physicians who perform abortions in the clinic to have admitting privileges with a hospital within a reasonable proximity to the clinic. Abortion clinics that perform only first trimester abortions must have such a transfer agreement, or physicians who perform abortions in the clinic must have such admitting privileges. The bill also defines "gestation" and the trimesters of pregnancy, which are not currently defined in the licensure act.

The bill requires the AHCA to perform annual licensure inspections of all abortion clinics, including a review of at least 50 percent of the patient records generated since the last inspection. The bill requires AHCA to submit an annual report to the President of the Senate and the Speaker of the House of Representatives which summarizes all regulatory actions it has taken against abortion clinics during the prior year.

The bill prohibits selling, purchasing, donating or transferring fetal remains obtained through an abortion, as well as advertising or offering to do any of the preceding acts.

The bill prohibits public funding for an organization that owns, operates, or is affiliated with a licensed abortion clinic, and provides exemptions to this prohibition.

The bill requires abortion referral or counseling agencies to register with AHCA, and AHCA must include actions against referral agencies in the annual report of ch. 390, F.S., licensure actions required by the bill.

The bill provides AHCA an appropriation of $59,951 in recurring and $185,213 in nonrecurring funding from the Health Care Trust Fund to implement the provisions of the bill. The bill also provides 0.5 FTE for additional inspections and records reviews as required in the bill. The bill has no impact on local government.

The bill provides an effective date of July 1, 2016 except as otherwise expressly provided in the act.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Federal Law on Abortion

Right to Abortion

In 1973, the foundation of modern abortion jurisprudence, *Roe v. Wade*[1], was decided by the U.S. Supreme Court. Using strict scrutiny, the Court determined that a woman's right to an abortion is part of a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulation limiting the exercise of this right must be justified by a compelling state interest, and must be narrowly drawn.[2] In 1992, the fundamental holding of *Roe* was upheld by the U.S. Supreme Court in *Planned Parenthood v. Casey*.[3]

Undue Burden

In *Planned Parenthood v. Casey*, the U.S. Supreme Court established the undue burden standard for determining whether a law places an impermissible obstacle to a woman's right to an abortion. The Court held that health regulations which impose undue burdens on the right to abortion are invalid.[4] State regulation imposes an "undue burden" on a woman's decision to have an abortion if it has the purpose or effect of placing a substantial obstacle in the path of the woman who seeks the abortion of a nonviable fetus.[5] However, the court opined, not every law which makes the right to an abortion more difficult to exercise is an infringement of that right.[6]

Physician Admitting Privileges

An admitting privilege is the right of a physician to admit patients to a particular hospital, and to provide specific services in that facility.[7] Ten states have enacted legislation requiring physicians who perform abortions to have admitting privileges with a local hospital.[8] The required distance between the location where the abortion is performed and the location of the hospital where the physician has admitting privileges varies in these statutes from within the same metropolitan area to within 30 miles.[9]

At least 10 states have enacted laws which require physicians who perform abortions to have hospital admitting privileges. Eight of these laws generated constitutional challenges.[10] In Wisconsin, a federal court ruled that the admitting privilege law was unconstitutional and permanently enjoined it.[11] In

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[1] *Roe v. Wade*, 410 U.S. 113 (1973).
[2] Id.
[3] *Casey*, 505 U.S. 833 (1992).
[4] Id. at 878.
[5] Id. at 877
[6] Id. at 873.
[7] *FAQ: The Next Abortion Battle: The Courts And Hospital Admitting-Privilege Laws*, Kaiser Health News, Julie Rovner, August 8, 2014. http://khn.org/news/abortion-admitting-privileges-fight/ (last visited January 25, 2016).In order for a physician to be granted privileges, a hospital generally checks the individual's medical credentials, license and malpractice history. Many hospitals also require physicians to admit a minimum number of patients to the hospital each year before they will grant or renew privileges. Others require the doctor to live within a minimum distance of the hospital.
[8] Alabama (Ala. Code 1975 s. 26-23E-4); Louisiana (LSA-R.S. 40:1061.10); Mississippi (Miss. Code Ann s. 41-75-1); Missouri (V.A.M.S. 188.080); North Dakota (NDCC 14-02.1-04); Oklahoma (Okla. Sess. Laws 370 (2014)); Tennessee (T.C.A. s. 39-15-202); Texas (V.T.C.A. s. 171.0031); and Wisconsin (W.S.A. 253.095).
[9] Alabama (Ala. Code 1975 s. 26-23E-4; and Texas (V.T.C.A. s. 171.0031), respectively.
[10] Admitting privilege laws in Tennessee and North Dakota were not challenged, and are in effect.
[11] *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015).

Alabama, Louisiana and Mississippi federal courts ruled the laws unconstitutional and enjoined them temporarily, but final orders have not yet issued and the cases are ongoing.[12] Similarly, in Oklahoma the Oklahoma Supreme Court temporarily enjoined the law without ruling on its constitutionality, and the case is ongoing.[13] Federal courts in Missouri and South Carolina upheld the admitting privilege laws, finding they did not violate the constitution.[14] Finally, in Texas, a federal court of appeal ruled that the admitting privilege law did not violate the constitution, but the U.S. Supreme Court stayed its effect pending appeal. That appeal is ongoing in the U.S. Supreme Court.[15]

In Florida, s. 390.012(3)(c), F.S., requires the medical director of an abortion clinic to have *either* admitting privileges at a licensed hospital in Florida, *or* a transfer agreement with a licensed hospital within "reasonable proximity" of the clinic. AHCA defines "reasonable proximity" in Rule 59A-9.019, F.A.C., as a distance not to exceed thirty minutes transport time by emergency vehicle. This requirement applies only to clinics which perform abortions after the first trimester. Individual physicians who perform abortions are not required to have admitting privileges or transfer agreements. Clinics that only provide abortions during the first trimester are not required to have transfer agreements or physicians with admitting privileges.

Federal Funding of Abortions

The Hyde Amendment is a rider to the annual appropriations bill for the U.S. Departments of Labor and Education, which prevents Medicaid and any other programs under these departments from funding abortions, except in limited cases. The Hyde Amendment does not prohibit the use of state or local public funds to pay for abortions.

The Hyde Amendment has been enacted into law in various forms since 1976.[16] In 1980, the U.S. Supreme Court affirmed the constitutionality of the Hyde Amendment in *Harris v. McRae*.[17] In *Harris*, the Court determined that funding restrictions created by the Hyde Amendment did not violate the U.S. Constitution's Fifth Amendment and, therefore, did not contravene the liberty or equal protection guarantees of the Due Process Clause of the Fifth Amendment.[18] The Court opined that, although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those obstacles that are not created by the government (in this case indigence).[19] The Court further opined that, although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all.[20]

Consistent with the Hyde Amendment, the Florida Medicaid program reimburses for abortions for the following reasons:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed;

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[12] *Planned Parenthood Southeast, Inc. v. Strange*, 33 F.Supp.3d 1330 (M.D. Ala. 2014) (non-final order); *June Medical Services, LLC v. Caldwell*, 2014 WL 4296679 (M.D. La. 2014) (non-final order); *Jackson Women's Health Organization v. Currier*, 760 F.3d 448 (5th Cir. 2014) (petition for certiorari currently pending before the United States Supreme Court).

[13] *Burns v. Cline*, District Court of Oklahoma County, State of Oklahoma, case no. 2014-cv-1896; 339 P.3d 887 (OK 2014) (order remanding to trial court for further proceedings). The case is pending with trial currently set for February 2016.

[14] *Women's Health Center of West County, Inc. v. Webster*, 871 F.2d 1377 (8th Cir. 1989); *Greenville Women's Clinic v. Comm'r, S.C. Dept. of Health and Environmental Control*, 317 F.3d 357 (4th Cir.) 2002; cert. den. 538 U.S. 1008 (U.S. 2003).

[15] *Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015); cert. granted 136 S.Ct. 499 (U.S. 2015).

[16] *See, e.g.*, Consolidated Appropriations Act of 2016, Pub. L. No. 114-113 (H.R. 2029, — 114th Congress (2015-2016). https://www.congress.gov/bill/114th-congress/house-bill/2029/text (last visited on January 15, 2016).

[17] 448 U.S. 297 (1980). *See also Rust v. Sullivan*, 500 U.S. 173 (1991), and *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), upholding *Harris v. McRae*.

[18] *Harris*, 448 U.S. at 326-27.

[19] *Harris*, *Id.* at 316-17.

[20] Id.

- The pregnancy is the result of rape (sexual battery) as defined in s. 794.011, F.S.; or
- The pregnancy is the result of incest as defined in s. 826.04, F.S.[21]

An Abortion Certification Form must be completed and signed by the physician who performed the abortion for the covered procedures. The form must be submitted with the facility claim, the physician's claim, and the anesthesiologist's claim. The physician must record the reason for the abortion in the physician's medical records for the recipient.[22]

Fetal Tissue Sale, Donation, and Research

Federal law prohibits the sale of fetal tissue: a person may not knowingly transfer fetal tissue for valuable consideration.[23] Federal law also prohibits directed donation for use in transplantation. This applies to a donation which is made pursuant to a promise that the fetal tissue will be transplanted in a specific individual, as well as for a donation in which the recipient has paid for the donor's abortion.[24] Finally, solicitation or acceptance of tissues from fetuses gestated for the purpose of research is prohibited.[25] This includes fetal tissue that was donated related to a pregnancy that was deliberately initiated to provide tissue for research or fetal tissue that was gestated in the uterus of a nonhuman animal.[26] Violation of any of these prohibitions can result in fines and imprisonment of up to 10 years.[27]

Federal law authorizes the Secretary of the U.S. Department of Health and Human Services to conduct or support research on the transplantation of human fetal tissue for therapeutic purposes.[28] The human fetal tissue used in the research may come from a spontaneous abortion, an induced abortion or a stillbirth.[29] However, before the fetal tissue may be used for research, informed consent must be obtained.

The woman electing to donate fetal tissue must sign a written statement declaring the donation is for research, made without restriction as to who may receive the tissue, and that she has not been informed of the identity of any potential recipients. The attending physician must sign a written statement declaring that the tissue has been donated with the woman's consent and that the physician fully disclosed any interest in the research and of any known medical or privacy risks to the woman. If the fetal tissue was obtained through an induced abortion, the physician must also attest that the physician obtained consent to the abortion prior to obtaining consent for the donation; that no alteration of the timing, method, or procedures used to terminate the pregnancy was made solely for the purposes of obtaining the tissue; and the abortion was performed in accordance with applicable state law. The researcher must sign a written statement declaring awareness that the tissue is human and that it has been donated as a result of an abortion or stillbirth; and that the researcher had no part in any decisions as to the timing, method, or procedures used to terminate the pregnancy.[30]

Florida Abortion Law

Right to Abortion

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[21] *See, e.g.*, Agency for Health Care Administration, Florida Medicaid Practitioner Services Coverage and Limitations Handbook, April 2014; and Agency for Health Care Administration, Florida Medicaid Managed Medical Assistance Program Model Contract, Attachment II, Exhibit II-A, Section V.(23), Nov. 11, 2015.
[22] Id.
[23] Valuable consideration does not include reasonable payments associated with the transportation, implantation, processing, preservation, quality control, or storage of human fetal tissue. 42 U.S. Code § 289g–2(a).
[24] 42 U.S. Code § 289g–2(b).
[25] 42 U.S. Code § 289g–2(c).
[26] Id.
[27] 42 U.S. Code § 289g–2(d).
[28] 42 U.S. Code § 289g–1.
[29] Id.
[30] Id.

The Florida Constitution, as interpreted by Florida courts, affords greater privacy rights than those provided by the U.S. Constitution. While the federal Constitution traditionally shields enumerated and implied individual liberties from state or federal intrusion, the U.S. Supreme Court has noted that state constitutions may provide greater protections.[31] Unlike the U.S. Constitution, Article I, s. 23 of the Florida Constitution contains an express right to privacy:

> Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

The Florida Supreme Court opined in *In re T.W.* that this section provides greater privacy rights than those implied by the U.S. Constitution. [32]

The Florida Supreme Court has recognized Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."[33] In *In re T.W.,* the Florida Supreme Court ruled that[34]:

> [P]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests....Under our Florida Constitution, the state's interest becomes compelling upon viability....Viability under Florida law occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical procedures.

The court recognized that after viability, the state can regulate abortion in the interest of the unborn child if the mother's health is not in jeopardy.[35]

Abortion Regulation

In Florida, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[36] An abortion must be performed by a physician[37] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing allopathic or osteopathic medicine in the employment of the United States.[38]

The Agency for Health Care Administration (AHCA) licenses and regulates abortion clinics in the state, pursuant to ch. 390, F.S., and part II of ch. 408, F.S.[39] Section 408.805, F.S., requires AHCA to establish license fees for all regulated facilities at a rate necessary to cover its administrative costs, unless otherwise limited by facility-specific statutes. That section also requires AHCA to increase the fees annually based on the Consumer Price Index. However, s. 390.014, F.S., limits licensure fees for abortion clinics to not less than $70 or more than $500. AHCA currently charges a biennial licensure fee of $545.00 pursuant to Rule 59A-9.020, F.A.C.

All abortion clinics and physicians performing abortions are subject to the following requirements:

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[31] *Pruneyard Shopping Center v. Robins*, 100 S.Ct. 2035, 2040 (1980), cited in *In re T.W.*, 551 So.2d 1186, 1191 (Fla. 1989).
[32] Id. at 1191-1192.
[33] Id. at 1192.
[34] Id. at 1193.
[35] Id. at 1194.
[36] Section 390.011(1), F.S.
[37] Section 390.0111(2), F.S.
[38] Section 390.011(8), F.S.
[39] Section 408.802(3) provides for the applicability of the Health Care Licensing Procedures Act to abortion clinics.

- An abortion may only be performed in a validly licensed hospital, abortion clinic, or in a physician's office;[40]
- An abortion clinic must be operated by a person with a valid and current license;[41]
- A third trimester abortion may only be performed in a hospital;[42]
- Proper medical care must be given and used for a fetus when an abortion is performed during viability;[43]
- Experimentation on a fetus is prohibited;[44]
- Except when there is a medical emergency, an abortion may only be performed after a patient has given voluntary and written informed consent;[45]
- Consent includes verification of the fetal age via ultrasound imaging;[46]
- Fetal remains are to be disposed of in a sanitary and appropriate manner;[47] and
- Parental notice must be given 48 hours before performing an abortion on a minor,[48] unless waived by a parent or otherwise ordered by a judge.

The level of regulation prescribed by AHCA depends on the trimester in which the abortion is being performed, and the viability of the fetus. However, current law does not define "trimester". Section 390.011(11), F.S., defines "third trimester" as the weeks of pregnancy after the 24th week of pregnancy. AHCA Rule 59A-9.019, F.A.C., defines the trimesters as follows:

> First Trimester. The first 12 weeks of pregnancy (the first 14 completed weeks from the last normal menstrual period).
> Second Trimester. That portion of a pregnancy following the 12th week and extending through the 24th week of gestation.
> Third Trimester. That portion of pregnancy beginning with the 25th week of gestation.

Current law does not define "gestation".[49]

For clinics performing only first trimester abortions, AHCA is required to adopt rules which are comparable to rules that apply to all surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions.[50] AHCA has not adopted a rule specific to first trimester-only facilities; rather, the regulations are those stated in the statute: abortions must be performed by a licensed physician at a licensed facility, and clinics must meet some minimal record-keeping and reporting requirements.[51] Other regulations related to first trimester abortions have been held unconstitutional, including rules which required first trimester abortion clinics and physicians to:[52]

- Maintain specified equipment in the clinic;
- Prepare a written pamphlet outlining post-operative treatment;
- Perform specified tests prior to the abortion procedure;

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[40] Section 797.03 (1), F.S.
[41] Section 797.03 (2), F.S.
[42] Section 797.03(3), F.S. The violation of any of these provisions results in a second degree misdemeanor.
[43] Section 390.0111(4), F.S.
[44] Section 390.0111(6), F.S.
[45] Section 390.0111(3), F.S. A physician violating this provision is subject to disciplinary action.
[46] Section 390.0111(3)(a)1.b., F.S.
[47] Section 390.0111(8), F.S. A person who improperly disposes of fetal remains commits a second degree misdemeanor.
[48] Section 390.01114(3), F.S. A physician who violates this provision is subject to disciplinary action.
[49] Ten states use gestation to measure trimesters, and measure gestation from fertilization: Georgia (Ga. Code Ann., § 31-9B-1); Idaho (I.C. § 18-604); Illinois (720 ILCS 510/2); Indiana (IC 16-18-2-287.5); Kentucky (KRS § 311.720); Minnesota (M.S.A. § 145.4241); Oklahoma (63 Okl.St.Ann. § 1-730); North Dakota (NDCC, 14-02.1-02); South Carolina (Code 1976 § 44-41-10); and South Dakota (SDCL § 34-23A-1). Other states measure gestation from the woman's last menstrual period, or do not specify.
[50] Section 390.012(2), F.S.
[51] Sections 390.0111(2); 390.0112; 390.014, F.S.
[52] *Florida Women's Medical Clinic, Inc. v. Smith*, 536 F.Supp. 1048 (S.D. Fla. 1982).

- Make available certain medications for post-operative treatment;
- Establish procedures to maintain proper sanitation; and
- Dispose of fetal remains in a nuisance-free manner.

AHCA has greater authority to establish rules for abortion clinics which perform abortions after the first trimester. Pursuant to s. 390.012(3), F.S., AHCA established by rule standards for: [53]

- Adequate private space for interviewing, counseling, and medical evaluations;
- Dressing rooms for staff and patients;
- Appropriate lavatory areas;
- Areas for pre-procedure hand-washing;
- Private procedure rooms;
- Adequate lighting and ventilation for procedures;
- Surgical or gynecological examination tables and other fixed equipment;
- Post-procedure recovery rooms that are equipped to meet the patients' needs;
- Emergency exits to accommodate a stretcher or gurney;
- Areas for cleaning and sterilizing instruments;
- Adequate areas for the secure storage of medical records and necessary equipment;
- Medical directors, personnel and staff training; and
- Conspicuous display of the clinic's license.

AHCA has broad authority to inspect abortion clinics, which must occur biennially and be unannounced.[54] AHCA has authority to inspect all records of abortion clinics.[55] The law does not specify the number or percent of records AHCA must review during an inspection.

DOH and AHCA have authority to take licensure action against practitioners and clinics, respectively, which violate licensure statutes or rules.[56] Additionally, abortion clinics are subject to criminal penalties for violation of certain statutes and rules.

Fetal Tissue Regulation

Section 873.05, F.S., prohibits anyone from advertising, selling, purchasing or otherwise transferring a human embryo for valuable consideration. "Valuable consideration" does not include the reasonable costs associated with the removal, storage, and transportation of a human embryo, and there is no prohibition against the donation of a human embryo. A violation of this section is a second degree felony. Section 873.01, F.S., prohibits the sale of any human organ or tissue for valuable consideration. In this section, "valuable consideration" does not include the reasonable costs associated with the removal, storage, and transportation of a human organ or tissue. Florida law does not address donation of fetal remains, or advertising for the transfer of fetal remains.[57]

Chapter 390, F.S., contains two standards for the disposal of fetal remains. Pursuant to s. 390.0111, F.S., all fetal remains must be disposed of in a "sanitary and appropriate" manner and in accordance with standard health practices established by DOH. Failure to dispose of fetal remains in accordance with department rules is a second degree misdemeanor.[58] Pursuant to s. 390.012, F.S., abortion clinics are required to dispose of fetal tissue in a "competent

[53] Ch. 59A-9, F.A.C.
[54] Section 408.811, F.S.
[55] Id.
[56] Section 390.018, F.S.
[57] Florida law also prohibits experimentation on any live fetus or infant either prior to or subsequent to an abortion unless it is necessary to preserve the life of such fetus or infant. S. 390.0111(6), F.S.
[58] Section 390.0111(7), F.S.

professional manner" consistent with the manner in which other human tissue is disposed.[59] Failure to adhere to this requirement is a first degree misdemeanor.[60]

Abortion Data Collection and Reporting Requirements

Section 390.0112 (1), F.S., requires facilities that perform abortions to submit a monthly report to AHCA containing the number of abortions performed, the reason for the procedure, and the gestational age of the fetus.

AHCA must keep this information in a central location from which statistical data can be drawn.[61] If the abortion is performed in a location other than a medical facility, the physician who performed the abortion is responsible for reporting the information to AHCA.[62] The reports are confidential and exempt from public records requirements.[63] AHCA may impose fines for violations of the reporting requirements.[64]

In 2014, DOH reported that there were 220,138 live births in the state of Florida.[65] In the same year, AHCA reported that there were 72,073 abortion procedures performed in the state. Of those:[66]

- 65,902 were performed in the first trimester (12 weeks and under);
- 6,171 were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over).

The majority of the procedures (65,210) were elective.[67] The remainder of the abortions were performed due to:[68]

- Emotional or psychological health of the mother (76);
- Physical health of the mother that was not life endangering (158);
- Life endangering physical condition (69);
- Rape (749);
- Serious fetal genetic defect, deformity, or abnormality (560); and
- Social or economic reasons (5,115).

The federal Centers for Disease Control and Prevention (CDC), compiles statistics voluntarily reported by the 50 states, the District of Columbia and New York City, related to termination of pregnancies to produce a national data report.[69] The last national data report was issued in 2012.[70] The CDC requests the following information from states for the U.S. Standard Report of Induced Termination of Pregnancy:

- Facility name (clinic or hospital);
- City, town or location;

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[59] Section 390.012(7), F.S.
[60] Id.
[61] Id.
[62] Section 390.0112(2), F.S.
[63] Section 390.0112(3), F.S.
[64] Section 390.0112(4), F.S.
[65] Correspondence from the Department of Health to the House of Representatives Health Quality Subcommittee dated February 26, 2015, on file with Health Quality Subcommittee Staff.
[66] Reported Induced Terminations of Pregnancy by Reason, By Weeks of Gestation for Calendar Year 2014, AHCA, on file with the Health Quality Subcommittee Staff.
[67] Id.
[68] Id.
[69] *Abortion Surveillance- United States, 2012*, Surveillance Summaries, Centers for Disease Control and Prevention, November 27, 2015 / 64(SS10);1-40 http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm?s_cid=ss6410a1_e (last visited on January 4, 2016).
[70] Id.

- County;
- Hospital or clinic's patient identification number (used for querying for missing information without identifying the patient);
- Age;
- Marital status;
- Date of termination;
- Residence of patient;
- Ethnicity;
- Race;
- Education attainment;
- Date of last menses;
- Clinical estimate of gestation;
- Previous pregnancy history;
- Previous abortion history;
- Type of abortion procedure; and
- Name of attending physician and name of person completing report.[71]

The CDC uses this data to provide an annual Abortion Surveillance Report (ASR). The CDC notes that they receive data from some states, but not all.[72] Florida only reports the annual number of terminations that occur in the state,[73] so Florida data is absent from 19 of the 22 statistical charts in the ASR. For example, Florida does not collect information on the number of teenagers who receive abortions, or on the race or ethnicity of abortion patients.[74]

TABLE 6. Reported abortions among adolescents, by known age and year — selected reporting areas,* United States, 2003–2012

	Year										% change			
Age (yrs)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003 to 2007	2008 to 2012	2011 to 2012	2003 to 2012
% of abortions														
<15	3.5	3.3	3.4	3.1	3.1	3.0	3.0	3.0	3.0	3.1	-11.4	3.3	3.3	**-11.4**
15	6.3	6.1	6.4	6.1	5.9	5.8	5.6	5.8	5.5	5.5	-6.3	-5.2	0.0	**-12.7**
16	11.6	11.6	11.4	11.6	11.3	10.8	10.6	10.3	10.0	9.8	-2.6	-9.3	-2.0	**-15.5**
17	17.3	16.9	17.1	17.3	17.4	17.1	16.9	16.3	16.1	15.6	0.6	-8.8	-3.1	**-9.8**
18	28.1	28.3	27.8	28.0	28.1	28.3	28.0	27.7	28.1	27.8	0.0	-1.8	-1.1	**-1.1**
19	33.2	33.8	33.9	34.0	34.1	34.9	35.9	36.8	37.2	38.2	2.7	9.5	2.7	**15.1**
Abortion rate†														
<15	1.4	1.2	1.2	1.2	1.2	1.1	1.0	1.0	0.8	0.7	-14.3	-36.4	-12.5	**-50.0**
15	5.1	4.7	4.6	4.6	4.4	4.3	3.9	3.6	3.1	2.6	-13.7	-39.5	-16.1	**-49.0**
16	9.4	9.0	8.5	8.6	8.3	7.8	7.1	6.3	5.5	4.7	-11.7	-39.7	-14.5	**-50.0**
17	14.0	13.3	13.0	13.2	12.6	12.3	11.2	9.9	8.7	7.3	-10.0	-40.7	-16.1	**-47.9**
18	22.4	22.0	21.0	21.4	20.8	19.6	18.0	16.2	14.9	12.8	-7.1	-34.7	-14.1	**-42.9**
19	26.9	25.9	25.3	26.0	25.4	24.9	22.5	21.1	19.0	17.2	-5.6	-30.9	-9.5	**-36.1**
Abortion ratio§														
<15	833	764	776	747	770	795	810	833	820	781	-7.6	-1.8	-4.8	**-6.2**
15	553	531	545	529	504	520	505	540	514	480	-8.9	-7.7	-6.6	**-13.2**
16	457	440	434	432	414	397	391	393	384	355	-9.4	-10.6	-7.6	**-22.3**
17	372	361	359	354	345	339	332	329	328	301	-7.3	-11.2	-8.2	**-19.1**
18	385	381	367	359	346	345	329	335	334	309	-10.1	-10.4	-7.5	**-19.7**
19	329	324	316	311	299	304	295	300	288	271	-9.1	-10.9	-5.9	**-17.6**
Total (no.)	**117,310**	**114,501**	**112,076**	**115,185**	**111,046**	**111,046**	**101,875**	**92,511**	**81,145**	**69,967**	—	—	—	—

* Data from 40 reporting areas; by year, these areas represent 90%–97% of all abortions reported to CDC for adolescents during 2003–2012. Excludes 12 reporting areas (California, District of Columbia, Florida, Illinois, Louisiana, Maine, Maryland, New Hampshire, Rhode Island, Vermont, West Virginia, and Wyoming) that did not report, did not report age among adolescents by individual year, or did not meet reporting standards for ≥1 year.

[71] Centers for Disease Control, Handbook on the Reporting of Induced Termination of Pregnancy, www.cdc.gov/nchs/data/misc/hb_itop.pdf (last visited on January 4, 2016).
[72] *Abortion Surveillance- United States, 2012*, Surveillance Summaries, Centers for Disease Control and Prevention, November 27, 2015 / 64(SS10);1-40 http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm?s_cid=ss6410a1_e (last visited on January 4, 2016).
[73] Id.
[74] Id.

Abortion Referral or Counseling Agencies

Chapter 390, F.S., also regulates abortion referral or counseling agencies. An "abortion referral or counseling agency" is any person, group, or organization that provides advice or help to persons in obtaining abortions.[75] These entities may be funded publicly or privately and are prohibited from charging or accepting any referral fees from a physician, hospital, clinic, or other medical facility.[76] Abortion referral or counseling agencies are required to provide an individual with a full explanation of an abortion, including alternatives to this procedure.[77] If the individual is a minor, then this explanation must also be provided to the parent or guardian of the minor.[78]

These requirements are not enforced by AHCA; rather, the law makes a violation of this section a first degree misdemeanor.

Public Funding for Abortion Providers and Affiliated Entities

DOH contracts with some providers to perform services under the Title V Maternal and Child Health[79] and Title X Family Planning[80] programs and for other contracted services like disability determinations and screening for sexually transmitted diseases. Some of those contracted providers perform, or are affiliated with entities that perform, abortions. For example, in Fiscal Year 2014-2015, DOH expended $139,128.60 on non-abortion contracted services provided by Planned Parenthood, and expects to spend $162,834.00 in Fiscal Year 2015-2016.[81]

Similarly, the Florida Medicaid program pays for non-abortion services provided by entities that perform, or are affiliated with entities that perform, abortions. For example, from July 2014 to June 2015, the Medicaid fee-for-service program paid $105,962.03 in claims to Planned Parenthood, and 10 plans in the Medicaid Managed Medical Assistance program contract with Planned Parenthood affiliates for non-abortion services.[82]

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[75] Section 390.025, F.S.
[76] Id.
[77] Id.
[78] Id.
[79] Title V of the Social Security Act authorizes federal funding for mothers and children through the Maternal and Child Services Program block grant. States apply for funding established by Congress, which is then allocated by a formula which considers the proportion of the number of low-income children in a particular state compared to the total number of low-income children in the United States. States must match every four dollars of federal Maternal and Child Services Block Grant money that they receive with at least three dollars of nonfederal money (state and/or local funds). The Maternal and Child Health program provides services for infants, children and pregnant women, particularly children with special health care needs, including: Comprehensive prenatal and postnatal care for women, especially low-income and at-risk pregnant women; health assessments and follow-up diagnostic and treatment services; preventive and child care services, and rehabilitative services for certain children; family-centered, community-based systems of coordinated care for children with special healthcare needs; and toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid. See, *MCH Block Grant*, Florida Department of Health, http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/mch-block-grant.html (last visited January 25, 2016); *Title V Maternal and Child Health Services Block Grant Program*, U.S. Department of Health and Human Services, http://mchb.hrsa.gov/programs/titlevgrants/ (last visited January 25, 2016).
[80] The Title X Family Planning program is a federal program that provides low-income or uninsured individuals with comprehensive family planning and related preventive health services. Nearly 4,200 Title X-funded family planning centers serve about 4.5 million clients a year, including state and local health departments, community health centers, Planned Parenthood centers and private, nonprofit programs (hospital-based, school-based and faith-based). Family planning centers offer FDA-approved contraceptive methods and related counseling, breast and cervical cancer screening, pregnancy testing and counseling, and screening and treatment for sexually transmitted infections, including HIV testing. Title X does not fund abortion as a method of family planning. (Title 42 U.S. Code § 300a–6.) See, *Title X: The National Family Planning Program*, U.S. Department of Health and Human Services, http://www.hhs.gov/opa/title-x-family-planning/ (last visited January 25, 2016).
[81] DOH email correspondence dated August 10, 2015, on file with Health Quality Subcommittee staff.
[82] AHCA email correspondence dated September 17, 2015, on file with Health Quality Subcommittee staff.

Effect of Proposed Changes

CS/HB 1411 amends abortion clinic licensure requirements, prohibits sale or donation of fetal remains, prohibits certain public funding, and creates a registration program for abortion referral and counseling agencies.

Abortion Regulations

The bill amends the licensure requirements for abortion clinics in ch. 390, F.S. The bill requires AHCA to perform annual, rather than biennial, licensure inspections of all abortion clinics. In those inspections, AHCA must review at least 50 percent of the patient records generated since the last inspection. AHCA is also required to promptly investigate allegations that unlicensed abortions are being performed at a clinic. The bill requires, AHCA to submit an annual report to the President of the Senate and the Speaker of the House of Representatives which summarizes all regulatory actions taken by it against abortion clinics and referral or counseling agencies during the prior year, beginning February 1, 2017.

The bill requires abortion clinics that perform abortions after the first trimester to have a written transfer agreement with a hospital within a reasonable proximity to the clinic, and requires physicians who perform abortions in the clinic to have admitting privileges with a hospital within a reasonable proximity to the clinic. Abortion clinics that perform only first trimester abortions must have such a transfer agreement, or physicians who perform abortions in the clinic must have such admitting privileges.

The bill defines "gestation" and the trimesters of pregnancy to delineate when the first, second and third trimesters begin and end. Under the bill, "gestation" is the development of a human embryo or fetus between fertilization and birth, and the trimesters are defined by 12-week increments counting from gestation.

The bill removes the abortion clinic statutory license fee cap of not less than $70 and not more than $500 and requires AHCA to establish fees which may not be more than required to pay for the costs incurred by AHCA in licensing and regulating abortion clinics.

Abortion Data Collection and Reporting

In addition to current reporting requirements, the bill requires all abortion clinics, by January 1, 2017, to report to AHCA information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the CDC. AHCA must submit this data to the CDC upon request.

Fetal Remains

Chapter 390, F.S., currently contains two methods, each with different standards and levels of criminal penalties, for the disposal of fetal remains. The bill eliminates this potential conflict by amending s. 390.0111, F.S., to require disposal of fetal remains in a sanitary manner pursuant to s. 381.0098, F.S., rules adopted thereunder and rules adopted by AHCA under this provision. Violations of this requirement are first degree misdemeanors.

The bill amends s. 873.025, F.S., to prohibit selling, purchasing, donating or transferring fetal remains obtained through an abortion, as well as advertising or offering to do any of those acts. These prohibitions do not apply to transfers that comply with s. 390.0111, F.S. (above).

Public Funding

The bill prohibits state agencies, local governmental entities, and Medicaid managed care plans from expending funds for the benefit of, pay funds to, or initiating or renewing a contract with an organization

that owns, operates, or is affiliated[83] with a licensed abortion clinic. The bill provides exceptions to this prohibition for any of the following circumstances:

- All abortions performed by the organization are due to rape or incest or are medically necessary to preserve the life of the pregnant woman;
- The public funds are expended to fulfill the terms of a contract entered into before July 1, 2016; and
- The funds are expended as reimbursement for Medicaid services provided on a fee-for-service basis.

State agencies and local governmental entities, including DOH and Medicaid managed care plans, may contract with other providers and organizations to perform services.

Abortion Referral or Counseling Agencies

The bill requires abortion referral or counseling agencies to register with AHCA. AHCA will set a registration fee which may not exceed the cost to administer the registration program. Facilities licensed pursuant to chapters 390, 395, 400 and 408, F.S., are exempt from registering, as are health care clinics and health care practitioners defined in s. 456.001, F.S., if they refer less than 6 patients each month. The bill allows AHCA to assess the costs of successful investigations and prosecutions of violations of the registration requirement, which costs do not include attorney's fees.

B. SECTION DIRECTORY:

Section 1: Amending s. 390.011, F.S., relating to definitions.
Section 2: Amending s. 390.0111, F.S., relating to termination of pregnancies.
Section 3: Amending s. 390.0112, F.S., relating to termination of pregnancies and reporting.
Section 4: Amending s. 390.012, F.S., relating to powers of agency, rules and disposal of fetal remains.
Section 5: Amending s. 390.014, F.S., relating to licenses fees.
Section 6: Amending s. 390.025, F.S., relating to abortion referral or counseling agencies and penalties.
Section 7: Amending s. 873.05, F.S., relating to advertising or sale of human embryos prohibited.
Section 8: Provides an appropriation.
Section 9: Provides an effective date of July 1, 2016, except as otherwise expressly provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill amends s. 390.014 (3), F.S. giving the agency authority to establish a fee not more than required to pay for the costs incurred by the agency in administering the program. AHCA currently collects $545 in licensure fees biennially for each clinic. AHCA reports that as of February 1, 2016 there will be 62 licensed abortion clinics. Current revenues received annually are estimated to be $16,895. If the Agency established fees to fully fund costs incurred with program administration, the Agency would increase the licensure fee by $1,933.90 for recurring costs and $5,974.61 to cover the nonrecurring cost. Licensure fees would be $8,453.51 in year one and $2,478.90 in year two and beyond. (See Fiscal Comments)

[83] For the Florida Medicaid program, s. 409.901, F.S., defines "affiliated" as "any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a Medicaid provider, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity".

2. Expenditures:

The bill requires AHCA to perform annual, rather than biennial, licensure inspections of all abortion clinics, including a review of at least 50 percent of the patient records generated since the last inspection. AHCA anticipates this will cause an increase in surveyor workload requiring an additional 0.50 full-time equivalent nurse surveyor position. This position will require $53,651 in recurring funds, $3,569 in nonrecurring funds, and 39,230 in salary rate.
The bill requires AHCA to collect and report information consistent with the United States Standard Report of Induced Termination of Pregnancy (ITOP) adopted by the CDC. Data systems changes will be required to AHCA's ITOP reporting system to be consistent with the bills reporting requirements. AHCA estimates programming and developer costs of $187,944 for the first year and $6,300 in recurring costs thereafter. (See Fiscal Comments)

The bill provides AHCA an appropriation of $59,951 in recurring and $185,213 in nonrecurring funding from the Health Care Trust Fund to implement the provisions of the bill. The bill also provides 0.5 FTE for additional inspections and records reviews as required in the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Abortion clinics may incur an indeterminate, negative fiscal impact associated with compliance with the bill's data reporting requirements.

The bill prohibits public funding for an organization that owns, operates, or is affiliated with a licensed abortion clinic. This applies to funding provided through local governmental entities, state agencies and managed care plans. This may result in an indeterminate, negative fiscal impact for clinics and associated business organizations.

Abortion referral and counseling agencies will incur a negative fiscal impact related to the bill's registration requirement.

D. FISCAL COMMENTS:

Revenues				
Annual Clinic Licensure Renewals	**License Fee**	**Year 1**	**Year 2**	**Note**
31	$545.00	$ 16,895.00	$ 16,895.00	Current Regulatory Fee
31	$1,730.68	$ 53,651.08	$ 53,651.08	Additional Personnel
31	$115.12	$ 3,568.72		Nonrecurring personnel costs
31	$203.23	$ 6,300.00	$ 6,300.00	Recurring System Maintenance
31	$5,859.48	$ 181,644.00		One time system upgrades and nonrecurring employee costs.
Total		**$ 262,058.80**	**$ 76,846.08**	
Annual Licensure Fee		**$ 8,453.51**	**$ 2,478.91**	
Expenditures				
Annual Licensure Expenditures	**FTE**	**Year One**	**Year Two**	**Note**
Current Licensure Administration Costs		$ 16,895.00	$ 16,895.00	Current Costs
Additional 0.5 FTE-Recurring	0.5	$ 53,651.00	$ 53,651.00	Recurring FTE costs
Additional 0.5 FTE nonrecurring	0.5	$ 3,569.00		Nonrecurring FTE costs
System Enhancements		$ 6,300.00	$ 6,300.00	Recurring System Maintenance
System Enhancements		$ 181,644.00		Nonrecurring System Modifications
Total		**$ 262,059.00**	**$ 76,846.00**	
Annual Licensure Costs		**$ 8,453.52**	**$ 2,478.90**	

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditure of funds; reduce the authority that counties and municipalities have to raise revenue in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   The bill requires clinics which perform only first trimester abortions to have a written patient transfer agreement with a hospital within a reasonable proximity, or the physician who performs the abortion must have admitting privileges at such a hospital. Florida courts have

limited regulation of first trimester abortions to certain minimal requirements, and invalidated prior regulations which exceeded these.[84]

Some federal courts have found that physician privilege requirements for abortion providers violate the U.S. Constitution.[85] Other courts have upheld these requirements, finding they do not violate the constitution.[86] The issue is currently before the U.S. Supreme Court.[87]

B. RULE-MAKING AUTHORITY:

AHCA currently has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 2, 2016, the Health Care Appropriations Subcommittee adopted one amendment. The amendment made the following change:

- Provides an appropriation of $59,951 in recurring and $185,213 in nonrecurring funding from the Health Care Trust Fund and 0.5 FTE to implement the provisions of the bill.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

[84] *Florida Women's Medical Clinic, Inc. v. Smith*, 536 F.Supp. 1048 (S.D. Fla. 1982).
[85] *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015); *Planned Parenthood Southeast, Inc. v. Strange*, 33 F.Supp.3d 1330 (M.D. Ala. 2014) (non-final order); *June Medical Services, LLC v. Caldwell*, 2014 WL 4296679 (M.D. La. 2014) (non-final order); *Jackson Women's Health Organization v. Currier*, 760 F.3d 448 (5th Cir. 2014) (petition for certiorari currently pending before the United States Supreme Court); *Burns v. Cline*, District Court of Oklahoma County, State of Oklahoma, case number 2014-cv-1896; 339 P.3d 887 (OK 2014)(order remanding to trial court for further proceedings).
[86] *Women's Health Center of West County, Inc. v. Webster*, 871 F.2d 1377 (8th Cir. 1989); *Greenville Women's Clinic v. Comm'r, S.C. Dept. of Health and Environmental Control*, 317 F.3d 357 (4th Cir.) 2002; cert. den. 538 U.S. 1008 (U.S. 2003);
[87] *Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015); cert. granted 136 S.Ct. 499 (U.S. 2015).

A bill to be entitled

An act relating to termination of pregnancies; amending s. 390.011, F.S.; defining the term "gestation" and revising the term "third trimester"; amending s. 390.0111, F.S.; revising the requirements for disposal of fetal remains; revising the criminal punishment for failure to properly dispose of fetal remains; prohibiting state agencies, local governmental entities, and Medicaid managed care plans from expending or paying funds to or initiating or renewing contracts under certain circumstances with certain organizations that perform abortions; providing exceptions; amending s. 390.0112, F.S.; requiring directors of certain hospitals and physicians' offices and licensed abortion clinics to submit monthly reports to the Agency for Health Care Administration on a specified form; prohibiting the report from including personal identifying information; requiring the agency to submit certain data to the Centers for Disease Control and Prevention on a quarterly basis; amending s. 390.012, F.S.; requiring the agency to develop and enforce rules relating to license inspections and investigations of certain clinics; requiring the agency to adopt rules that require certain clinics to have written agreements with local hospitals for certain

contingencies; specifying that the rules must require physicians who perform abortions at a clinic that performs abortions in the first trimester of pregnancy to have admitting privileges at a hospital within reasonable proximity to the clinic; revising requirements for rules that prescribe minimum recovery room standards; revising requirements for the disposal of fetal remains; requiring the agency to submit an annual report to the Legislature; amending s. 390.014, F.S.; providing a different limitation on the amount of a fee; amending s. 390.025, F.S.; requiring certain organizations that provide abortion referral services or abortion counseling services to register with the agency, pay a specified fee, and include certain information in advertisements; requiring biennial renewal of a registration; providing exemptions from the registration requirement; requiring the agency to adopt rules; providing for the assessment of costs in certain circumstances; amending s. 873.05, F.S.; prohibiting an offer to purchase, sell, donate, or transfer fetal remains obtained from an abortion and the purchase, sale, donation, or transfer of such remains, excluding costs associated with certain transportation of remains; providing an appropriation; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (6) through (12) of section 390.011, Florida Statutes, are redesignated as subsections (7) through (13), respectively, a new subsection (6) is added to that section, and present subsection (11) of that section is amended, to read:

390.011 Definitions.—As used in this chapter, the term:

(6) "Gestation" means the development of a human embryo or fetus between fertilization and birth.

(12)~~(11)~~ "~~Third~~ Trimester" means one of the following three distinct periods of time in the duration of a pregnancy:

(a) "First trimester," which is the period of time from fertilization through the end of the 11th week of gestation.

(b) "Second trimester," which is the period of time from the beginning of the 12th week of gestation through the end of the 23rd week of gestation.

(c) "Third trimester," which is the period of time from the beginning of the 24th week of gestation through birth ~~the weeks of pregnancy after the 24th week of pregnancy~~.

Section 2. Subsection (7) of section 390.0111, Florida Statutes, is amended, and subsection (15) is added to that section, to read:

390.0111 Termination of pregnancies.—

(7) FETAL REMAINS.—Fetal remains shall be disposed of in a sanitary ~~and appropriate~~ manner pursuant to s. 381.0098 and

rules adopted thereunder ~~and in accordance with standard health practices, as provided by rule of the Department of Health~~. Failure to dispose of fetal remains in accordance with this subsection ~~department rules~~ is a misdemeanor of the first ~~second~~ degree, punishable as provided in s. 775.082 or s. 775.083.

(15) USE OF PUBLIC FUNDS RESTRICTED.—A state agency, a local governmental entity, or a managed care plan providing services under part IV of chapter 409 may not expend funds for the benefit of, pay funds to, or initiate or renew a contract with an organization that owns, operates, or is affiliated with one or more clinics that are licensed under this chapter and perform abortions unless one or more of the following applies:

(a) All abortions performed by such clinics are:

1. On fetuses that are conceived through rape or incest; or

2. Are medically necessary to preserve the life of the pregnant woman or to avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman, other than a psychological condition.

(b) The funds must be expended to fulfill the terms of a contract entered into before July 1, 2016.

(c) The funds must be expended as reimbursement for Medicaid services provided on a fee-for-service basis.

Section 3. Subsection (1) of section 390.0112, Florida Statutes, is amended, present subsections (2), (3), and (4) of that section are redesignated as subsections (3), (4), and (5),

respectively, and a new subsection (2) is added to that section, to read:

390.0112 Termination of pregnancies; reporting.—

(1) The director of any medical facility in which abortions are performed, including a physician's office, ~~any pregnancy is terminated~~ shall submit a ~~monthly~~ report each month to the agency. The report may be submitted electronically, may not include personal identifying information, and must include:

(a) Until the agency begins collecting data under paragraph (e), the number of abortions performed.

(b) The reasons such abortions were performed.

(c) For each abortion, the period of gestation at the time the abortion was performed.

(d) ~~which contains the number of procedures performed, the reason for same, the period of gestation at the time such procedures were performed, and~~ The number of infants born alive or alive ~~during or~~ immediately after an attempted abortion.

(e) Beginning no later than January 1, 2017, information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention.

(2) The agency shall keep ~~be responsible for keeping~~ such reports in a central location for the purpose of compiling and analyzing ~~place from which~~ statistical data and shall submit data reported pursuant to paragraph (1)(e) to the Division of Reproductive Health within the Centers for Disease Control and

Prevention, as requested by the Centers for Disease Control and Prevention ~~analysis can be made~~.

Section 4. Paragraph (c) of subsection (1), subsection (2), and paragraphs (c) and (f) of subsection (3) of section 390.012, Florida Statutes, are amended, present paragraphs (g) and (h) of subsection (3) are redesignated as paragraphs (h) and (i), respectively, a new paragraph (g) is added to that subsection, subsection (7) of that section is amended, and subsection (8) is added to that section, to read:

390.012 Powers of agency; rules; disposal of fetal remains.—

(1) The agency may develop and enforce rules pursuant to ss. 390.011-390.018 and part II of chapter 408 for the health, care, and treatment of persons in abortion clinics and for the safe operation of such clinics.

(c) The rules shall provide for:

1. The performance of pregnancy termination procedures only by a licensed physician.

2. The making, protection, and preservation of patient records, which shall be treated as medical records under chapter 458. When performing a license inspection of a clinic, the agency shall inspect at least 50 percent of patient records generated since the clinic's last license inspection.

3. Annual inspections by the agency of all clinics licensed under this chapter to ensure that such clinics are in compliance with this chapter and agency rules.

4. The prompt investigation of credible allegations of abortions being performed at a clinic that is not licensed to perform such procedures.

(2) For clinics that perform abortions in the first trimester of pregnancy only, these rules must ~~shall~~ be comparable to rules that apply to all surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions and must require:

(a) Clinics to have a written patient transfer agreement with a hospital within reasonable proximity to the clinic which includes the transfer of the patient's medical records held by the clinic and the treating physician to the licensed hospital; or

(b) Physicians who perform abortions at the clinic to have admitting privileges at a hospital within reasonable proximity to the clinic.

(3) For clinics that perform or claim to perform abortions after the first trimester of pregnancy, the agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter, including the following:

(c) Rules relating to abortion clinic personnel. At a minimum, these rules shall require that:

1. The abortion clinic designate a medical director who is licensed to practice medicine in this state, and all physicians who perform abortions in the clinic have ~~who has~~ admitting privileges at a ~~licensed~~ hospital within reasonable proximity to

the clinic ~~in this state or has a transfer agreement with a licensed hospital within reasonable proximity of the clinic~~.

2. If a physician is not present after an abortion is performed, a registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant ~~shall~~ be present and remain at the clinic to provide postoperative monitoring and care until the patient is discharged.

3. Surgical assistants receive training in counseling, patient advocacy, and the specific responsibilities associated with the services the surgical assistants provide.

4. Volunteers receive training in the specific responsibilities associated with the services the volunteers provide, including counseling and patient advocacy as provided in the rules adopted by the director for different types of volunteers based on their responsibilities.

(f) Rules that prescribe minimum recovery room standards. At a minimum, these rules must ~~shall~~ require that:

1. Postprocedure recovery rooms be ~~are~~ supervised and staffed to meet the patients' needs.

2. Immediate postprocedure care consist ~~consists~~ of observation in a supervised recovery room for as long as the patient's condition warrants.

~~3. The clinic arranges hospitalization if any complication beyond the medical capability of the staff occurs or is suspected.~~

3.~~4.~~ A registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant who is trained in the management of the recovery area and is capable of providing basic cardiopulmonary resuscitation and related emergency procedures remain ~~remains~~ on the premises of the abortion clinic until all patients are discharged.

4.~~5.~~ A physician ~~shall~~ sign the discharge order and be readily accessible and available until the last patient is discharged to facilitate the transfer of emergency cases if hospitalization of the patient or viable fetus is necessary.

5.~~6.~~ A physician discuss ~~discusses~~ Rho(D) immune globulin with each patient for whom it is indicated and ensure ~~ensures~~ that it is offered to the patient in the immediate postoperative period or ~~that it~~ will be available to her within 72 hours after completion of the abortion procedure. If the patient refuses the Rho(D) immune globulin, she and a witness must sign a refusal form approved by the agency which must be ~~shall be signed by the patient and a witness and~~ included in the medical record.

6.~~7.~~ Written instructions with regard to postabortion coitus, signs of possible problems, and general aftercare which are specific to the patient be ~~are~~ given to each patient. The instructions must include information ~~Each patient shall have specific written instructions~~ regarding access to medical care for complications, including a telephone number for use in the event of a ~~to call for~~ medical emergency ~~emergencies~~.

7.~~8.~~ ~~There is~~ A ~~specified~~ minimum length of time be

specified, by type of abortion procedure and duration of gestation, during which ~~that~~ a patient must remain ~~remains~~ in the recovery room ~~by type of abortion procedure and duration of gestation~~.

8.~~9.~~ The physician ensure ~~ensures~~ that, with the patient's consent, a registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant from the abortion clinic makes a good faith effort to contact the patient by telephone~~, with the patient's consent,~~ within 24 hours after surgery to assess the patient's recovery.

9.~~10.~~ Equipment and services be ~~are~~ readily accessible to provide appropriate emergency resuscitative and life support procedures pending the transfer of the patient or viable fetus to the hospital.

(g) Rules that require clinics to have a written patient transfer agreement with a hospital within reasonable proximity to the clinic which includes the transfer of the patient's medical records held by both the clinic and the treating physician.

(7) If an ~~any~~ owner, operator, or employee of an abortion clinic fails to dispose of fetal remains and tissue in a sanitary manner pursuant to s. 381.0098, rules adopted thereunder, and rules adopted by the agency pursuant to this section ~~consistent with the disposal of other human tissue in a competent professional manner~~, the license of such clinic may be suspended or revoked, and such person commits ~~is guilty of~~ a

misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) Beginning February 1, 2017, and annually thereafter, the agency shall submit a report to the President of the Senate and the Speaker of the House of Representatives which summarizes all regulatory actions taken during the prior year by the agency under this chapter.

Section 5. Subsection (3) of section 390.014, Florida Statutes, is amended to read:

390.014 Licenses; fees.—

(3) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this chapter and part II of chapter 408. The amount of the fee shall be established by rule and may not be more than required to pay for the costs incurred by the agency in administering this chapter ~~less than $70 or more than $500~~.

Section 6. Effective January 1, 2017, present subsection (3) of section 390.025, Florida Statutes, is amended, and new subsections (3), (4), and (5) are added to that section, to read:

390.025 Abortion referral or counseling agencies; penalties.—

(3) An abortion referral or counseling agency, as defined in subsection (1), shall register with the Agency for Health Care Administration. To register or renew a registration an applicant must pay an initial or renewal registration fee

established by rule, which must not exceed the costs incurred by the agency in administering this section. Registrants must include in any advertising materials the registration number issued by the agency and must renew their registration biennially.

(4) The following are exempt from the requirement to register pursuant to subsection (3):

(a) Facilities licensed pursuant to this chapter, chapter 395, chapter 400, or chapter 408;

(b) Facilities that are exempt from licensure as a clinic under s. 400.9905(4) and that refer five or fewer patients for abortions per month; and

(c) Health care practitioners, as defined in s. 456.001, who, in the course of their practice outside of a facility licensed pursuant to this chapter, chapter 395, chapter 400, or chapter 408, refer five or fewer patients for abortions each month.

(5) The agency shall adopt rules to administer this section and part II of chapter 408.

(6)~~(3)~~ Any person who violates the provisions of subsection (2) commits ~~this section is guilty of~~ a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. In addition to any other penalties imposed pursuant to this chapter, the Agency for Health Care Administration may assess costs related to an investigation of violations of this section which results in a successful prosecution. Such costs

may not include attorney fees.

Section 7. Section 873.05, Florida Statutes, is amended to read:

873.05 Advertising, purchase, ~~or~~ sale, or transfer of human embryos or fetal remains prohibited.—

(1) A ~~No~~ person may not ~~shall~~ knowingly advertise or offer to purchase or sell, or purchase, sell, or otherwise transfer, a ~~any~~ human embryo for valuable consideration.

~~(2)~~ As used in this subsection ~~section~~, the term "valuable consideration" does not include the reasonable costs associated with the removal, storage, and transportation of a human embryo.

(2) A person may not advertise or offer to purchase, sell, donate, or transfer, or purchase, sell, donate, or transfer, fetal remains obtained from an abortion, as defined in s. 390.011. This subsection does not prohibit the transportation or transfer of fetal remains for disposal pursuant to s. 381.0098 or rules adopted thereunder.

(3) A person who violates ~~the provisions of~~ this section commits ~~is guilty of~~ a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 8. For the 2016-2017 fiscal year, 0.5 full-time equivalent positions, with associated salary rate of 39,230, are authorized and the sums of $59,951 in recurring funds and $185,213 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing this act.

Section 9. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Burton offered the following:

Amendment (with title amendment)

Remove lines 183-184 and insert:

the clinic, unless the clinic ~~in this state or~~ has a written patient transfer agreement with a ~~licensed~~ hospital within reasonable proximity to ~~of~~ the clinic which includes the transfer of the patient's medical records held by both the clinic and the treating physician.

Remove lines 249-253

T I T L E A M E N D M E N T

Remove lines 25-31 and insert:

to require all physicians performing abortions to have admitting privileges with a hospital within a reasonable proximity unless the clinic has a transfer agreement with the hospital; revising

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 1411 (2016)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION		
ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Hill offered the following:

Amendment

Remove lines 91-94 and insert:

(a) All abortions performed by such clinics are medically necessary to preserve the life of the

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 819 Sunset Review of Medicaid Dental Services
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 994

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 1 N	Langston	Poche
2) Health & Human Services Committee		Langston	Calamas

SUMMARY ANALYSIS

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program. The SMMC program requires the Agency for Health Care Administration (AHCA) to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental services, through a Managed Medical Assistance (MMA) program. In February 2014, AHCA executed 5-year contracts for the MMA program, and began implementation, which was completed August 1, 2014. As of December 2015, over 3.89 million Medicaid recipients enrolled in the MMA program receive services, including dental health benefits, through MMA plans.

A Medicaid prepaid dental health plan (PDHP) is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services. Prior to implementing the MMA program, Florida used PDHPs to deliver dental services to children enrolled in Medicaid.

HB 819 removes dental services from the list of minimum benefits that MMA plans must provide, effective March 1, 2019. Instead, effective July 1, 2017, AHCA must implement a statewide PDHP program for children and adults and begin enrollment by March 1, 2019. AHCA must contract with at least two licensed dental managed care providers through a competitive procurement process to provide dental benefits. AHCA is authorized to seek any necessary state plan amendment or federal waivers to implement the statewide PDHP program.

The bill creates s. 409.973(5), F.S., which requires AHCA to prepare a comprehensive report on dental services provided under the SMMC program. The report must examine the effectiveness of the managed care plans in providing dental care, improving access to dental care and dental health, and achieving satisfactory outcomes for recipients and providers. The report must also track the historical trends of rate payments to providers and plan subcontractors, provider participation in dental networks, and provider willingness to treat recipients. Finally, the report must compare Florida's experience in providing dental services to Medicaid recipients with the experiences of other states in delivering the same services, increasing access to care, and overall dental health. AHCA may contract with an independent third party, if necessary, to assist in the preparation of the report.

The bill authorizes the Legislature to use the findings of the report to establish the scope of minimum benefits under the MMA program for future procurements of eligible plans; specifically, the Legislature may use the findings of the report to determine whether dental benefits should be benefits under the MMA program or be provided separately. If the Legislature determines dental services should be provided by the MMA plans, it must repeal the changes made in this bill before July 1, 2017.

The bill may have significant negative fiscal impact on the Medicaid program, and a significant negative fiscal impact to AHCA.

Except as otherwise provided, the bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal- and state-funded program that provides health care for low-income Floridians, administered by the Agency for Health Care Administration (AHCA) under ch. 409, F.S. Federal law establishes the mandatory services to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906, F.S., respectively.

Statewide Medicaid Managed Care

In 2010, the Florida House of Representatives contracted with a consultant to analyze Florida's Medicaid program and identify problems and possible solutions; the consultant concluded that Florida Medicaid's fragmented, complex system made it difficult to improve value for patients and taxpayers.[1] As a result, in 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S.

The SMMC program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. A unified, coordinated system of care is a primary characteristic of the SMMC program, in part because it solves the problem of complexity with which Florida's Medicaid program was plagued by for decades. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[2] Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.[3] Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees, including dental services.[4]

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[5] AHCA selected 19 managed care plans (MMA plans) and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide by of August 1, 2014.[6] As of December 2015, approximately 3.89 million Medicaid recipients are enrolled in the MMA program.[7]

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[1] Medicaid Managed Care Study, Pacific Health Policy Group, p. 73, March 2010

[2] This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.

[3] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, available at http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf (last visited February 5, 2016).

[4] The other component of the SMMC program is the Long-Term Care Managed Care Program.

[5] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2, Solicitations Number: AHCA ITN 017-12/13*; dated February 26, 2013 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm; AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Solicitation Number: AHCA ITN 017-12/13*; dated December 28, 2012 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited February 5, 2016).

[6] Agency for Health Care Administration, Agency Analysis of 2016 House Bill 819, p. 3, January 6, 2105 (on file with Health and Human Services Committee staff).

[7] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Report: December 2015*, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_December_2015.xls (last visited February 5, 2016).

AHCA expects to competitively procure the next round of contracts in May 2017, and make awards to plans in May 2018.[8] AHCA further expects those MMA plans to begin providing services in September 2019.[9]

Waivers for Medicaid Managed Care

The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Florida operated its previous Medicaid dental program under a 1915(b) waiver, which expired on January 31, 2014. AHCA did not seek renewal of the waiver; instead, the federal government agreed to give a series of temporary extensions while AHCA implemented the Statewide Medicaid Managed Care (SMMC) program. The temporary extensions of the 1915(b) waiver allowed dental services to be gradually folded into the SMMC program. To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority, which provides authority to include dental services in the SMMC program.

Dental Care in the MMA Program

Under federal law, dental services are an optional Medicaid benefit.[10] Florida provides full dental services for children and limited dental services for adults.[11] Currently, Medicaid recipients must enroll in an MMA plan to receive covered services, including dental services. The MMA plans participating in the SMMC have developed their dental networks both by subcontracting with prepaid dental health plan (PDHPs)[12] and directly contracting with dentists.

All MMA plans provide full dental services, not currently covered under the Medicaid state plan, to adult enrollees. Through these dental benefits, adult Medicaid recipients have access to expanded dental services, including preventive services.[13] Examples of these additional benefits include twice-yearly exams and cleanings, fluoride treatments, fillings, and yearly x-rays.[14] Not only do these benefits exceed what is required by law, AHCA negotiated their inclusion within the MMA plans at no cost to the state.[15] AHCA initially estimated the value of the additional benefits at $100 million over five years;[16] however, the value may end up being in excess of that. From May 1, 2014, to January 25, 2016, the MMA plans spent $84,600,000 on expanded dental benefits to adults.[17]

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[8] *Supra*, note 6 at 6.
[9] Id.
[10] 42 U.S.C. § 1396a(72).
[11] S. 409.906(1), (6), F.S. Adults must be provided dentures and medically necessary, emergency dental procedures to alleviate pain or infection.
[12] A Medicaid PDHP is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services to enrollees.
[13] *Supra*, note 6 at 3-4.
[14] Information provided by AHCA and on file with the Health Innovation Subcommittee.
[15] Agency for Health Care Administration, *Agency Analysis of 2014 House Bill 27*, November 25, 2013 (on file with Health and Human Services Committee staff).
[16] Id.
[17] Email from Orland Pryor, Deputy Director of Legislative Affairs, Agency for Health Care Administration Staff, Questions, February 1, 2016, (on file with Health and Human Services Committee staff). The amount was calculated based on the approved expanded adult dental procedures codes for encounters for dental claims and procedures for recipients over the age of 18.

Dental Service Accountability and Performance in the MMA Program

MMA program contracts impose various accountability provisions and performance measures on the MMA plans, specific to dental services.

First, there are specific requirements for network adequacy for all MMA plans, to ensure a sufficient number of primary and specialty dental care providers are available to meet the needs of plan enrollees.[18] Each plan must have at least one full time primary dental provider in each service area and at least one full time primary dental provider for every 1500 enrollees.[19] Since July 2014, 213,819 adult enrollees have received dental benefits under the MMA program.[20] Dentist participation in Medicaid has increased over 26 percent since the implementation of the MMA program. As of October 2015, there were 2,378 dentists participating in the MMA program as either fee-for-service (FFS) dental providers in the Medicaid program or non-FFS providers in the Medicaid program, who registered for encounter data purposes.[21]

Provider Type[22]	*November 2013*	*October 2015*	*Total % Change*
FFS Fully Enrolled Dentists	1,414	1,575	11.39%
Registered Dentists	470	803	70.85%
Total Participating Dentists	1,884	2,378	26.22%

Second, MMA plans must maintain an annual medical loss ratio (MLR) of a minimum of 85 percent for the first full year of MMA program operation.[23] The MLR measures the amount of money spent on providing services to enrollees against the amount of money spent on administrative functions;[24] an MLR of 85 percent requires 85 percent of the capitation paid to the MMA plan to be expended on health care services, including dental services. The MLR must also take into account, as required in the terms and conditions of the 1115 waiver, any payments of the achieved savings rebate, which requires:

- 100 percent of income up to, and including, five percent of revenue to be retained by the plan;
- 50 percent of income above five percent and up to ten percent to be retained by the plan, with the other 50 percent returned to the state; and
- 100 percent of income above ten percent of revenue to be returned to the state.[25]

In addition, under the terms and conditions of the 1115 waiver, AHCA must work with MMA plans on an oral health quality improvement initiative. The MMA program contracts[26] have specific performance goals for pediatric dental services and penalties for not reaching these goals. Each MMA plan is required to provide a Child Health Check-Up (CHCUP) to every enrollee. The CHCUP includes dental screenings and referrals starting at age three, or earlier if indicated.[27] The MMA plans must achieve a CHCUP rate of at least 80 percent for children enrolled for eight continuous months.[28] A plan that fails

[18] *MMA Model Agreement, Attachment II, Exhibit II A*, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf (last visited February 5, 2016).
[19] Id. at 103.
[20] Email correspondence with Agency for Health Care Administration Staff on HB 819, December, 28, 2015 (on file with Health and Human Services Committee staff).
[21] Id.
[22] Participating Providers are providers that have submitted a paid claim within twelve months of the report's run date.
[23] *Supra*, note 18.
[24] U.S. Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR)*, https://www.healthcare.gov/glossary/medical-loss-ratio-MLR/ (last visited February 5, 2016).
[25] S. 409.967(3), F.S.; AHCA established a uniform method for the plans to use for annually reporting premium revenue, medical and administrative costs, and income or losses. Using the reporting method, the plans calculate whether they have achieved a savings for the reporting year and whether they must pay a rebate to the state.
[26] Agency for Health Care Administration, *SMMC Plans: Model Contract*, available at: http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last visited February 5, 2016).
[27] *Supra*, note 18 at 22.
[28] Id. at 22, 109.

to meet this goal is subject to a corrective action plan[29] and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[30]

The MMA plans are also required to achieve a preventive dental services rate of at least 28 percent for children enrolled for 90 continuous days.[31] A plan that fails to meet this goal is subject to a corrective action plan and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[32] For both the CHCUP and preventive dental services, the MMA plan must provide transportation to and from the child's dental appointments, if needed.

Lastly, the MMA plans are required to have Healthcare Effectiveness Data and Information Set (HEDIS)[33] scores above 50 percent for pediatric dental services or face liquidated damages. This requires a significant improvement over the PDHPs and reform county pilot plans. The liquidated damages for failure to meet the HEDIS scores will be calculated based on the number of members enrolled in the MMA plan.

Dental Care Prior to the SMMC Program

Prior to the implementation of the SMMC program, dental services were provided to Medicaid recipients in a number of ways. Children and adults enrolled in Medicaid health plans in the five reform pilot counties received their dental care through comprehensive managed care health plans.[34] Children outside of the reform pilot counties were required to access their dental services through PDHPs under contract with AHCA to provide children's dental services.[35] Adults enrolled in the Medicaid program, outside of the reform pilot counties, received their dental services either through the fee-for-service system or through health plans that chose to include Medicaid adult dental services in the benefit package.[36] The adult dental services were limited to dentures and medically necessary, emergency dental procedures to alleviate pain or infection.[37]

Prepaid Dental Health Plans (PDHPs)

In 2001, Florida began using a PDHP to deliver dental services to children as a pilot program in Miami-Dade County.[38] In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing AHCA to contract with PDHPs in other areas[39] and permitted AHCA to include the Medicaid reform pilot counties.[40] In 2011, the Legislature made PDHP contracting mandatory, not discretionary, outside the reform pilot counties and Miami-Dade County.[41] However, the Legislature limited the use of PHDPs for fiscal year 2012-2013, by requiring that AHCA not limit dental services to PDHPs and allow dental services to be provided on a fee-for-service basis, as well.[42]

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[29] The Corrective Action Plan details the actions to be taken by the MMA Plan to reach the rate.
[30] *Supra*, note 18 at 22, 109.
[31] Id. at 22, 110.
[32] Id.
[33] HEDIS measures are developed by the National Committee for Quality Assurance (NCQA), and allow for comparison of otherwise dissimilar health plans.
[34] *Supra*, note 6 at 4.
[35] Id.
[36] Id.
[37] S. 409.906(1), F.S.
[38] Proviso language in the 2001 General Appropriations Act (GAA) authorized AHCA to initiate a PDHP pilot program in Miami-Dade County. Similar statutory authority was provided in 2003.
[39] Ch. 2003-405 s. 18, Laws of Fla. (codified as. 409.912(42), F.S.).
[40] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five-year waiver was set to expire June 30, 2011, but was renewed through June 30, 2014.
[41] Ch. 2011-135 s. 17, Laws of Fla. (codified as s. 409.912(41), F.S.). This subsection expired October 1, 2014.
[42] Ch. 2012-119 s. 9, Laws of Fla. (codified as s. 409.912(41)(b), F.S.). This paragraph expired July 1, 2013.

AHCA issued a competitive procurement for the statewide PDHP program in 2011 and awarded contracts to two PDHPs to provide dental services to Medicaid recipients in all Florida counties with the exceptions noted above.[43] The contracts with PDHP providers expired on September 30, 2014.[44] On October 1, 2014, the statutory authority for AHCA to contract with PDHPs expired, as the program transitioned to the comprehensive managed care contracts in the new MMA program.

PDHP Accountability and Performance

Like the MMA program contracts, PDHP contracts imposed specific requirements for network adequacy;[45] required plans to meet an MLR of 85 percent;[46] and required plans to provide CHCUP to enrollees[47] and achieve an annual screening and participation CHCUP rate of 80 percent.[48] Unlike the MMA plans, which must have HEDIS scores over 50 percent, the PDHPs were only required to have an "acceptable HEDIS score" or potentially be subject to unspecified monetary damages.[49]

Performance of the PDHPs and MMA Plans, Compared

AHCA measures the performance of the MMA plans, and measured the performance of PDHPs, based on HEDIS scores. To ensure the validity of HEDIS results, the data is reviewed by certified auditors using a process designed by the NCQA.[50]

AHCA conducted an independent analysis to determine the percentage of MMA enrollees ages 2 – 21 years who received at least one dental service during the first year of MMA implementation, from August 1, 2014 through July 31, 2015.[51] AHCA used the same parameters used to calculate the HEDIS scores for children's dental care annual dental visits, with two variations:

- HEDIS uses a calendar year; AHCA used an August through July time period; and
- HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; AHCA's analysis required that they be enrolled on July 31 of the measurement year.[52]

Using these parameters, AHCA determined that 43 percent of the children who qualified to be counted in this measure received dental services during this time period.[53] This score is higher than the HEDIS score achieved in 2013 by Medicaid reform plans of 42 percent which, until MMA, was the highest score ever recorded for this measure in Florida.

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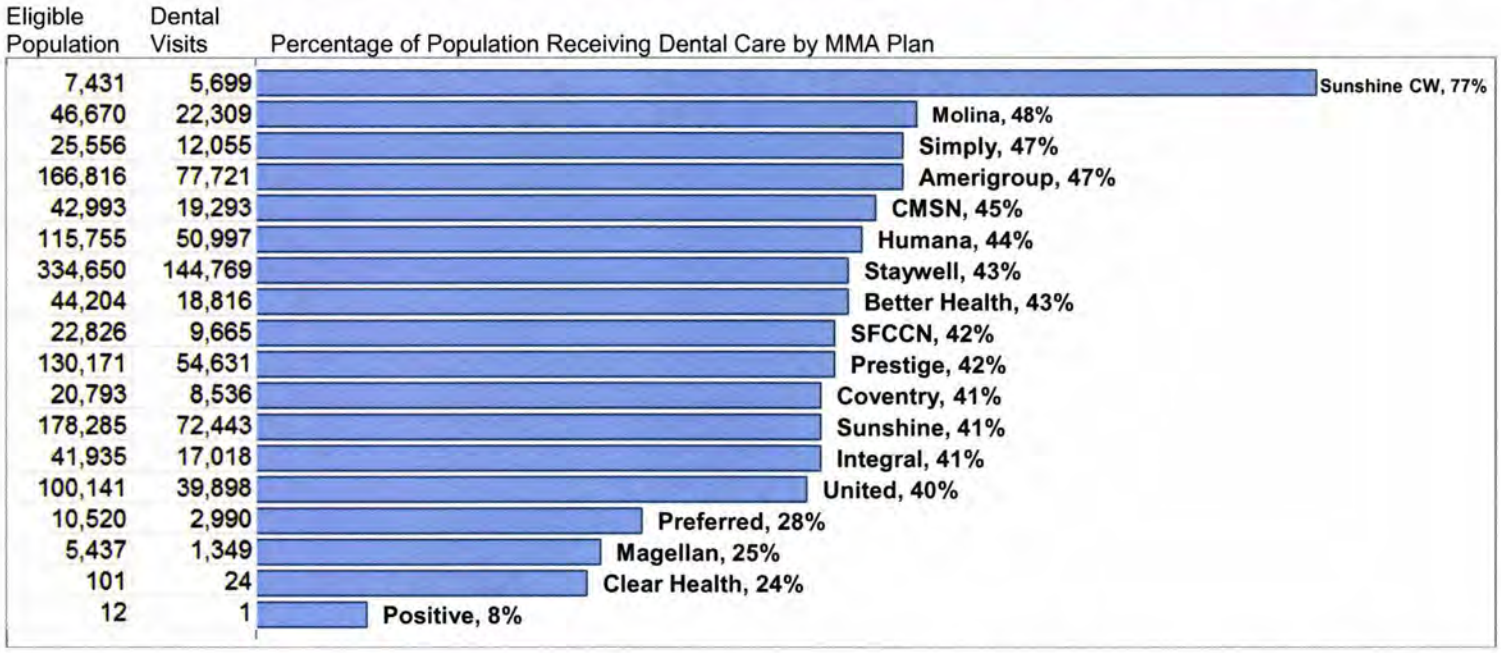
[43] During 2012, AHCA implemented the statewide PDHP program in Medicaid Area 9 on January 1; Areas 5, 6, and 7 on October 1; and Areas 1, 2, 3, 4, 8, and 11 (Monroe County only) on December 1, 2012.
[44] The original procurement period was December 1, 2011 through September 30, 2013. The program was renewed once, which extended the contracts through September 30, 2014.
[45] Agency for Health Care Administration, *Medicaid Prepaid Dental Health Plan Contract, Attachment II, January, 2012*, p. 60 (on file with Health and Human Services Committee staff).
[46] In calendar year 2013, both PDHPs failed to meet the required MLR and were required to repay AHCA an estimated $20 million. Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with Health and Human Services Committee staff).
[47] *Supra*, note 45 at 53-54.
[48] Id.
[49] Id. at 83. "Acceptable HEDIS score" was not defined in the PDHP contracts.
[50] National Committee for Quality Assurance, *HEDIS and Quality Measurement: What is HEDIS?*, available at: http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx (last visited February 5, 2016).
[51] *Supra*, notes 20; 54.
[52] Id.
[53] Id.

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years[54]

Time Period	MMA Plans	Reform Pilot Plans[55]	PDPHs (MCNA[56] and DentaQuest[57])
CY 2007 (Reported in 2008)	N/A	*15.2%*	N/A
CY 2008 (Reported in 2009)	N/A	*28.5%*	N/A
CY 2009 (Reported in 2010)	N/A	*33.4%*	N/A
CY 2010 (Reported in 2011)	N/A	*34.0%*	N/A
CY 2011 (Reported in 2012)	N/A	*35.3%*	N/A
CY 2012 (Reported in 2013)	N/A	**40.40%**	**40.92%**
CY 2013 (Reported in 2014)	N/A	**42.3%**	**37.04%**
MMA Year 1	**43.1%**	N/A	N/A

The chart does not reflect HEDIS annual dental visit scores for either the MMA plans or pre-MMA plans calendar year 2014 because 2014 was the MMA transition year, so the data is not representative of performance.[58]

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years by MMA Plan, MMA Year 1[59]



[54] Justin M. Senior, Florida Medicaid Director, Agency for Health Care Administration, *Florida Medicaid: Statewide Medicaid Managed Care*, PowerPoint Presentation to the House Health and Human Services Committee, January 2016. (Presentation on file with Health and Human Services Committee staff).

[55] The data for the Reform Pilot Plans indicate an initial improvement from 2007 to 2009, followed by relatively static numbers over the next few years from 2009 to 2011, followed by another improvement from 2011 to 2013.

[56] MCNA self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2010 to 2011 showing 34.8 and 35 percent, respectively. (Information on file with Health and Human Services Committee staff).

[57] DentaQuest self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2005 to 2011 showing an increase from 20 percent in 2005 to 39.1 percent in 2011. (Information on file with Health and Human Services Committee staff).

[58] For enrollees to be counted, for the purpose of the HEDIS score, they must have been in a single plan for at least 11 out of 12 months and must have been enrolled in that plan as of December 31, 2014. Neither the PDHP nor reform pilot plans remained in effect as of December 31, 2014. Additionally, data for the MMA plans 2014 calendar year is not accurate because the number of enrollees counted in the scores are artificially low. Due to the transition to MMA program throughout 2014, there were very few enrollees who had been in an MMA plan for the required time that could then be counted for the 2014 HEDIS score.

[59] Agency for Health Care Administration, *Florida Medicaid: Data Visualization Series*, https://bi.ahca.myflorida.com/t/FLMedicaid/views/DentalProfileMMAYear1/DENTALSERVICES-MMA?:embed=y&:toolbar=no&:display_count=no (last visited February 5, 2016).

Effect of the Proposed Changes

Dental Services Carve-Out

Removal of Dental Services from MMA Plan Coverage

HB 819 amends s. 409.973(1), F.S., to remove "dental services" as a minimum benefit that must be included in future MMA plans. Presently all MMA plans are required to provide dental services, as medically necessary, to their enrollees.[60] Absent Legislative action before July 1, 2017, MMA plans would no longer provide child or adult dental services; instead, dental services would be provided through a statewide Medicaid PDHP, starting March 1, 2019.

The carve-out of dental services from the MMA program would represent a departure from the system of care that was created through Medicaid reform. As a result of the carve-out, Medicaid patients would no longer receive integrated, coordinated care. Additionally, adult Medicaid recipients would lose the expanded dental benefits they receive through the MMA plans.

Creation of a Statewide Medicaid PDHP Program

Effective July 1, 2017, AHCA must implement a statewide PDHP program for children and adults and begin enrollment by March 1, 2019. To establish the program, the bill requires AHCA contract with at least two licensed dental managed care providers through a competitive procurement process. The providers must have substantial experience in providing dental care to Medicaid enrollees and children eligible for assistance under the Children's Health Insurance Program and meet all AHCA standards and requirements. Provider contracts will be for five years and may not be renewed; however, contracts may be extended to cover delays during a transition to a new provider.

The bill requires PDHP contracts to include an MLR provision consistent with the current statutory MLR calculation requirement for MMA plans.[61] Currently, the MLR calculation must use uniform financial data collected from all plans and must be computed for each plan on a statewide basis. AHCA anticipates that it would need actuarial analysis services to create capitation rates for the new dental managed care plans selected and to separate dental services from the MMA program.[62]

The bill does not specify the level of adult dental services required in the statewide Medicaid PDHP program. The scope of adult dental services provided in the MMA plans exceeds the statutory requirements at no additional cost. The bill does not require the statewide Medicaid PDHP program to provide the same level of adult dental services that are currently offered in the MMA program. The bill appears to limit dental services to those required by s. 409.906(1),(6), F.S.; that is, full benefits for children and limited benefits (dentures and emergency procedures) for adults.

The bill authorizes AHCA to seek a state plan amendment or a federal waiver to begin enrollment into the prepaid dental program no later than March 1, 2019. AHCA anticipates that it would need to seek a new 1115 or 1915(b) waiver to enable it to implement the statewide Medicaid PDHP program.[63]

[60] The removal of dental services from the list of minimum benefits that MMA plans must provide will require AHCA to amend the current 1115 waiver authorizing the SMMC program to cover dental services separately, or apply for a 1915(b) waiver, which would allow AHCA to competitively procure prepaid dental plans and operate them as capitated managed care plans. Additionally, the removal of dental services would require AHCA to amend the SMMC plan contracts to exclude dental services as a covered service and modify existing capitation rates. *Supra*, note 6 at 4-7.
[61] S. 409.967(4), F.S.
[62] *Supra*, note 6 at 7.
[63] Id.

Comprehensive Report on Provision of Dental Services under the SMMC Program

The bill creates subsection (5) of s. 409.973, F.S., which requires AHCA to complete a comprehensive report[64] on the provision of dental services under the SMMC program. The report must examine the effectiveness of MMA plans in:

- Increasing access to dental care;
- Improving dental health;
- Achieving satisfactory outcomes for recipients and providers;
- Providing outreach to recipients; and
- Delivering value and transparency regarding funds intended for, and spent on, actual dental services.

The report must also examine, by MMA plan and in total:

- Historical trends of rates paid to providers and dental plan subcontractors;
- Provider participation in plan networks; and
- Provider willingness to treat recipients.

Finally, the report must also compare Florida's experience in providing dental care to Medicaid recipients with other states in delivering dental services, increasing access to dental care, and improving dental health.

The bill appears to give AHCA discretion to determine the specific metrics used to evaluate the MMA plans, and to determine how to weigh and reports on the topics included in the report. Nothing in the bill expressly precludes AHCA from considering additional elements when evaluating the MMA plans, provided those elements touch on at least one of the topics that must be addressed in the report.

The report is due by December 1, 2016 and must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Legislative Use of the Comprehensive Report

The bill states that the Legislature may use the findings of the report to establish the minimum benefits under the MMA program for future procurements of managed care plans. Specifically, the bill authorizes Legislature to consider the findings from the report when deciding whether to continue to include dental services as a minimum benefit under the MMA program or to provide dental services separately. If the bill is enacted, and the Legislature later wishes to keep dental services as a minimum benefit that plans must provide under the MMA program, the 2016 chapter law section reflecting the proposed removal of dental services from the list of minimum benefits must be repealed before July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.973, relating to benefits, effective March 1, 2019.
Section 2: Amends s. 409.973, relating to benefits.
Section 3: Provides an effective date of July 1, 2016, except as otherwise expressly provided.

[64] The bill grants AHCA the authority to contract with an independent third party to assist in the preparation of the report.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA estimates a contract with an independent entity to assist in preparing the comprehensive report will cost $250,000.[65]

   Additionally, if AHCA implements a statewide PDHP program, it estimates that it would need an additional $200,000 per year for the current contracted actuarial firm to perform analysis services necessary to amend the current plan capitation rates to remove dental services and to create capitation rates for the selected plans.[66] AHCA also anticipates using outside counsel for the defense of competitive procurement specifications and bid awards for the statewide PDHP program, at a cost of $100,000.[67]

   AHCA also anticipates the need for five FTE positions to implement the bill: one grade 26 FTE to manage waiver oversight, one grade 26 FTE for financial monitoring, and three grade 25 FTEs as contract managers.[68] According to AHCA, each FTE would need to be hired at 8 percent above minimum to recruit and retain quality staff.[69] To fund these additional positions, AHCA would require recurring General Revenue funds as follows:

State Fiscal Year	State General Revenue	Medicaid Care Trust Fund	Total
2016-17	$225,000	$225,000	$450,000
2017-18	$261,428	$261,428	$522,856
2018-19	$235,720	$235,720	$471,440

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   Adult Medicaid recipients may see increased dental care costs. Without the requirement to provide a dental benefit under the MMA program, it may no longer be cost effective for plans to maintain a full dental network, which may impact the plans' ability and willingness to continue to offer expanded dental benefits to adults.[70]

D. FISCAL COMMENTS:

   None.

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[65] *Supra*, note 6 at 9.
[66] Id.
[67] Id.
[68] Id. at 7.
[69] Id. at 9.
[70] Id. at 5.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Due to the potential for overlap and conflict between AHCA's anticipated procurement schedule for the MMA program and the timeline specified in the bill for the PDHP program, AHCA recommends that any benefit changes be postponed from March 1, 2019 to October 1, 2019.[71]

AHCA previously noted that creating a carve-out for any single service would set a bad precedent for the future of the new, reformed SMMC program.[72] AHCA expressed concern that removing dental services from the MMA plans could incentivize other service providers to seek carve-outs from the Legislature in the future.[73] Additional providers seeking carve-outs would undermine the unified, coordinated care provided to enrollees in the SMMC program. AHCA has also noted that there is no data or evidence to suggest that the current approach to providing dental services through the MMA program is flawed in design, network adequacy, quality, or implementation, or in need of change.[74]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[71] Id. 4-7.
[72] *Supra*, note 15.
[73] Id.
[74] Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with Health and Human Services Committee staff).

A bill to be entitled

An act relating to the sunset review of Medicaid Dental Services; amending s. 409.973, F.S.; providing for the future removal of dental services as a minimum benefit of managed care plans; requiring the Agency for Health Care Administration to provide a report to the Governor and the Legislature; specifying requirements for the report; providing for the use of the report's findings; requiring the agency to implement a statewide Medicaid prepaid dental health program upon the occurrence of certain conditions; specifying requirements for the program and the selection of providers; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective March 1, 2019, subsection (1) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

~~(e) Dental services.~~

(e) ~~(f)~~ Early periodic screening diagnosis and treatment services for recipients under age 21.

(f) ~~(g)~~ Emergency services.

(g) ~~(h)~~ Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the agency of that election when submitting a reply to an invitation to negotiate.

(h) ~~(i)~~ Healthy start services, except as provided in s. 409.975(4).

(i) ~~(j)~~ Hearing services.

(j) ~~(k)~~ Home health agency services.

(k) ~~(l)~~ Hospice services.

(l) ~~(m)~~ Hospital inpatient services.

(m) ~~(n)~~ Hospital outpatient services.

(n) ~~(o)~~ Laboratory and imaging services.

(o) ~~(p)~~ Medical supplies, equipment, prostheses, and orthoses.

(p) ~~(q)~~ Mental health services.

(q) ~~(r)~~ Nursing care.

(r) ~~(s)~~ Optical services and supplies.

(s) ~~(t)~~ Optometrist services.

(t) ~~(u)~~ Physical, occupational, respiratory, and speech therapy services.

(u) ~~(v)~~ Physician services, including physician assistant services.

(v) ~~(w)~~ Podiatric services.

(w) ~~(x)~~ Prescription drugs.

(x) ~~(y)~~ Renal dialysis services.

(y) ~~(z)~~ Respiratory equipment and supplies.

(z) ~~(aa)~~ Rural health clinic services.

(aa) ~~(bb)~~ Substance abuse treatment services.

(bb) ~~(cc)~~ Transportation to access covered services.

Section 2. Subsection (5) is added to section 409.973, Florida Statutes, to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(a) The agency shall provide a comprehensive report on the provision of dental services under this part to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016. The agency is authorized to contract with an independent third party to assist in the preparation of the report required by this paragraph.

1. The report must examine the effectiveness of medical managed care plans in increasing patient access to dental care, improving dental health, achieving satisfactory outcomes for Medicaid recipients and the dental provider community, providing outreach to Medicaid recipients, and delivering value and transparency to the state's taxpayers regarding the dollars intended for, and spent on, actual dental services. Additionally, the report must examine, by plan and in the aggregate, the historical trends of rates paid to dental

providers and to dental plan subcontractors, dental provider participation in plan networks, and provider willingness to treat Medicaid recipients. The report must also compare current and historical efforts and trends and the experiences of other states in delivering dental services, increasing patient access to dental care, and improving dental health.

2. The Legislature may use the findings of this report in setting the scope of minimum benefits set forth in this section for future procurements of eligible plans as described in s. 409.966. Specifically, the decision to include dental services as a minimum benefit under this section, or to provide Medicaid recipients with dental benefits separate from the Medicaid managed medical assistance program described in this part, may take into consideration the data and findings of the report.

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act and who meet all agency standards and requirements. The contracts for program providers shall be awarded through a competitive procurement process. The contracts must be for 5 years and may not be renewed; however, the agency may extend the

term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019.

Section 3. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 819 Medicaid Dental Services
SPONSOR(S): Health & Human Services Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee		Langston	Calamas

SUMMARY ANALYSIS

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program. The SMMC program requires the Agency for Health Care Administration (AHCA) to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental services, through a Managed Medical Assistance (MMA) program. In February 2014, AHCA executed 5-year contracts for the MMA program, and began implementation, which was completed August 1, 2014. As of December 2015, over 3.89 million Medicaid recipients enrolled in the MMA program receive services, including dental health benefits, through MMA plans.

A Medicaid prepaid dental health plan (PDHP) is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services. Prior to implementing the MMA program, Florida used PDHPs to deliver dental services to children enrolled in Medicaid.

PCS for HB 819 requires AHCA to provide a comprehensive report on how dental services have been provided to Medicaid recipients in the state by MMA plans in the MMA program, statewide and regional Medicaid PDHPs, and the non-managed care state plan program prior to the MMA program. The report must document and compare each delivery model's effectiveness at increasing patient access to dental care, improving dental health, and achieving satisfactory outcomes for Medicaid recipients. Additionally, the report must examine, by plan and in the aggregate, the historical trends of dental provider participation in plan networks.

The PCS permits the Legislature to use the report findings to set the scope of minimum benefits under the MMA program for future plan procurements. Specifically, the Legislature may use report findings to determine whether to maintain dental services as a minimum benefit in the MMA program or to provide Medicaid dental benefits separate from the MMA program.

The report is due to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016.

The PCS provides an effective date of upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal- and state-funded program that provides health care for low-income Floridians, administered by the Agency for Health Care Administration (AHCA) under ch. 409, F.S. Federal law establishes the mandatory services to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906, F.S., respectively.

Statewide Medicaid Managed Care

In 2010, the Florida House of Representatives contracted with a consultant to analyze Florida's Medicaid program and identify problems and possible solutions; the consultant concluded that Florida Medicaid's fragmented, complex system made it difficult to improve value for patients and taxpayers.[1] As a result, in 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S.

The SMMC program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. A unified, coordinated system of care is a primary characteristic of the SMMC program, in part because it solves the problem of complexity with which Florida's Medicaid program was plagued by for decades. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[2] Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.[3] Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees, including dental services.[4]

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[5] AHCA selected 19 managed care plans (MMA plans) and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide by of August 1, 2014.[6] As of December 2015, approximately 3.89 million Medicaid recipients are enrolled in the MMA program.[7]

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[1] Medicaid Managed Care Study, Pacific Health Policy Group, p. 73, March 2010

[2] This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.

[3] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, available at http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf (last visited February 5, 2016).

[4] The other component of the SMMC program is the Long-Term Care Managed Care Program.

[5] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2, Solicitations Number: AHCA ITN 017-12/13*; dated February 26, 2013 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm; AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Solicitation Number: AHCA ITN 017-12/13*; dated December 28, 2012 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited February 5, 2016).

[6] Agency for Health Care Administration, Agency Analysis of 2016 House Bill 819, p. 3, January 6, 2105 (on file with Health and Human Services Committee staff).

[7] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Report: December 2015*, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_December_2015.xls (last visited February 5, 2016).

AHCA expects to competitively procure the next round of contracts in May 2017, and make awards to plans in May 2018.[8] AHCA further expects those MMA plans to begin providing services in September 2019.[9]

Waivers for Medicaid Managed Care

The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Also, section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Florida operated its previous Medicaid dental program under a 1915(b) waiver, which expired on January 31, 2014. AHCA did not seek renewal of the waiver; instead, the federal government agreed to give a series of temporary extensions while AHCA implemented the Statewide Medicaid Managed Care (SMMC) program. The temporary extensions of the 1915(b) waiver allowed dental services to be gradually folded into the SMMC program. To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority, which provides authority to include dental services in the SMMC program.

Dental Care in the MMA Program

Under federal law, dental services are an optional Medicaid benefit.[10] Florida provides full dental services for children and limited dental services for adults.[11] Currently, Medicaid recipients must enroll in an MMA plan to receive covered services, including dental services. The MMA plans participating in the SMMC have developed their dental networks both by subcontracting with prepaid dental health plan (PDHPs)[12] and directly contracting with dentists.

All MMA plans provide full dental services, not currently covered under the Medicaid state plan, to adult enrollees. Through these dental benefits, adult Medicaid recipients have access to expanded dental services, including preventive services.[13] Examples of these additional benefits include twice-yearly exams and cleanings, fluoride treatments, fillings, and yearly x-rays.[14] Not only do these benefits exceed what is required by law, AHCA negotiated their inclusion within the MMA plans at no cost to the state.[15] AHCA initially estimated the value of the additional benefits at $100 million over five years;[16] however, the value may end up being in excess of that. From May 1, 2014, to January 25, 2016, the MMA plans spent $84,600,000 on expanded dental benefits to adults.[17]

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[8] *Supra*, note 6 at 6.
[9] Id.
[10] 42 U.S.C. § 1396a(72).
[11] S. 409.906(1), (6), F.S. Adults must be provided dentures and medically necessary, emergency dental procedures to alleviate pain or infection.
[12] A Medicaid PDHP is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services to enrollees.
[13] *Supra*, note 6 at 3-4.
[14] Information provided by AHCA and on file with the Health Innovation Subcommittee.
[15] Agency for Health Care Administration, *Agency Analysis of 2014 House Bill 27*, November 25, 2013 (on file with Health and Human Services Committee staff).
[16] Id.
[17] Email from Orland Pryor, Deputy Director of Legislative Affairs, Agency for Health Care Administration Staff, Questions, February 1, 2016, (on file with Health and Human Services Committee staff). The amount was calculated based on the approved expanded adult dental procedures codes for encounters for dental claims and procedures for recipients over the age of 18.

Dental Service Accountability and Performance in the MMA Program

MMA program contracts impose various accountability provisions and performance measures on the MMA plans, specific to dental services.

First, there are specific requirements for network adequacy for all MMA plans, to ensure a sufficient number of primary and specialty dental care providers are available to meet the needs of plan enrollees.[18] Each plan must have at least one full time primary dental provider in each service area and at least one full time primary dental provider for every 1500 enrollees.[19] Since July 2014, 213,819 adult enrollees have received dental benefits under the MMA program.[20] Dentist participation in Medicaid has increased over 26 percent since the implementation of the MMA program. As of October 2015, there were 2,378 dentists participating in the MMA program as either fee-for-service (FFS) dental providers in the Medicaid program or non-FFS providers in the Medicaid program, who registered for encounter data purposes.[21]

Provider Type[22]	*November 2013*	*October 2015*	*Total % Change*
FFS Fully Enrolled Dentists	1,414	1,575	11.39%
Registered Dentists	470	803	70.85%
Total Participating Dentists	1,884	2,378	26.22%

Second, MMA plans must maintain an annual medical loss ratio (MLR) of a minimum of 85 percent for the first full year of MMA program operation.[23] The MLR measures the amount of money spent on providing services to enrollees against the amount of money spent on administrative functions;[24] an MLR of 85 percent requires 85 percent of the capitation paid to the MMA plan to be expended on health care services, including dental services. The MLR must also take into account, as required in the terms and conditions of the 1115 waiver, any payments of the achieved savings rebate, which requires:

- 100 percent of income up to, and including, five percent of revenue to be retained by the plan;
- 50 percent of income above five percent and up to ten percent to be retained by the plan, with the other 50 percent returned to the state; and
- 100 percent of income above ten percent of revenue to be returned to the state.[25]

In addition, under the terms and conditions of the 1115 waiver, AHCA must work with MMA plans on an oral health quality improvement initiative. The MMA program contracts[26] have specific performance goals for pediatric dental services and penalties for not reaching these goals. Each MMA plan is required to provide a Child Health Check-Up (CHCUP) to every enrollee. The CHCUP includes dental screenings and referrals starting at age three, or earlier if indicated.[27] The MMA plans must achieve a CHCUP rate of at least 80 percent for children enrolled for eight continuous months.[28] A plan that fails

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[18] *MMA Model Agreement, Attachment II, Exhibit II A*, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf (last visited February 5, 2016).

[19] Id. at 103.

[20] Email correspondence with Agency for Health Care Administration Staff on HB 819, December, 28, 2015 (on file with Health and Human Services Committee staff).

[21] Id.

[22] Participating Providers are providers that have submitted a paid claim within twelve months of the report's run date.

[23] *Supra*, note 18.

[24] U.S. Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR)*, https://www.healthcare.gov/glossary/medical-loss-ratio-MLR/ (last visited February 5, 2016).

[25] S. 409.967(3), F.S.; AHCA established a uniform method for the plans to use for annually reporting premium revenue, medical and administrative costs, and income or losses. Using the reporting method, the plans calculate whether they have achieved a savings for the reporting year and whether they must pay a rebate to the state.

[26] Agency for Health Care Administration, *SMMC Plans: Model Contract*, available at: http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last visited February 5, 2016).

[27] *Supra*, note 18 at 22.

[28] Id. at 22, 109.

to meet this goal is subject to a corrective action plan[29] and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[30]

The MMA plans are also required to achieve a preventive dental services rate of at least 28 percent for children enrolled for 90 continuous days.[31] A plan that fails to meet this goal is subject to a corrective action plan and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[32] For both the CHCUP and preventive dental services, the MMA plan must provide transportation to and from the child's dental appointments, if needed.

Lastly, the MMA plans are required to have Healthcare Effectiveness Data and Information Set (HEDIS)[33] scores above 50 percent for pediatric dental services or face liquidated damages. This requires a significant improvement over the PDHPs and reform county pilot plans. The liquidated damages for failure to meet the HEDIS scores will be calculated based on the number of members enrolled in the MMA plan.

Dental Care Prior to the SMMC Program

Prior to the implementation of the SMMC program, dental services were provided to Medicaid recipients in a number of ways. Children and adults enrolled in Medicaid health plans in the five reform pilot counties received their dental care through comprehensive managed care health plans.[34] Children outside of the reform pilot counties were required to access their dental services through PDHPs under contract with AHCA to provide children's dental services.[35] Adults enrolled in the Medicaid program, outside of the reform pilot counties, received their dental services either through the fee-for-service system or through health plans that chose to include Medicaid adult dental services in the benefit package.[36] The adult dental services were limited to dentures and medically necessary, emergency dental procedures to alleviate pain or infection.[37]

Prepaid Dental Health Plans (PDHPs)

In 2001, Florida began using a PDHP to deliver dental services to children as a pilot program in Miami-Dade County.[38] In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing AHCA to contract with PDHPs in other areas[39] and permitted AHCA to include the Medicaid reform pilot counties.[40] In 2011, the Legislature made PDHP contracting mandatory, not discretionary, outside the reform pilot counties and Miami-Dade County.[41] However, the Legislature limited the use of PHDPs for fiscal year 2012-2013, by requiring that AHCA not limit dental services to PDHPs and allow dental services to be provided on a fee-for-service basis, as well.[42]

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[29] The Corrective Action Plan details the actions to be taken by the MMA Plan to reach the rate.
[30] *Supra*, note 18 at 22, 109.
[31] Id. at 22, 110.
[32] Id.
[33] HEDIS measures are developed by the National Committee for Quality Assurance (NCQA), and allow for comparison of otherwise dissimilar health plans.
[34] *Supra*, note 6 at 4.
[35] Id.
[36] Id.
[37] S. 409.906(1), F.S.
[38] Proviso language in the 2001 General Appropriations Act (GAA) authorized AHCA to initiate a PDHP pilot program in Miami-Dade County. Similar statutory authority was provided in 2003.
[39] Ch. 2003-405 s. 18, Laws of Fla. (codified as. 409.912(42), F.S.).
[40] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five-year waiver was set to expire June 30, 2011, but was renewed through June 30, 2014.
[41] Ch. 2011-135 s. 17, Laws of Fla. (codified as s. 409.912(41), F.S.). This subsection expired October 1, 2014.
[42] Ch. 2012-119 s. 9, Laws of Fla. (codified as s. 409.912(41)(b), F.S.). This paragraph expired July 1, 2013.

AHCA issued a competitive procurement for the statewide PDHP program in 2011 and awarded contracts to two PDHPs to provide dental services to Medicaid recipients in all Florida counties with the exceptions noted above.[43] The contracts with PDHP providers expired on September 30, 2014.[44] On October 1, 2014, the statutory authority for AHCA to contract with PDHPs expired, as the program transitioned to the comprehensive managed care contracts in the new MMA program.

PDHP Accountability and Performance

Like the MMA program contracts, PDHP contracts imposed specific requirements for network adequacy;[45] required plans to meet an MLR of 85 percent;[46] and required plans to provide CHCUP to enrollees[47] and achieve an annual screening and participation CHCUP rate of 80 percent.[48] Unlike the MMA plans, which must have HEDIS scores over 50 percent, the PDHPs were only required to have an "acceptable HEDIS score" or potentially be subject to unspecified monetary damages.[49]

Performance of the PDHPs and MMA Plans, Compared

AHCA measures the performance of the MMA plans, and measured the performance of PDHPs, based on HEDIS scores. To ensure the validity of HEDIS results, the data is reviewed by certified auditors using a process designed by the NCQA.[50]

AHCA conducted an independent analysis to determine the percentage of MMA enrollees ages 2 – 21 years who received at least one dental service during the first year of MMA implementation, from August 1, 2014 through July 31, 2015.[51] AHCA used the same parameters used to calculate the HEDIS scores for children's dental care annual dental visits, with two variations:

- HEDIS uses a calendar year; AHCA used an August through July time period; and
- HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; AHCA's analysis required that they be enrolled on July 31 of the measurement year.[52]

Using these parameters, AHCA determined that 43 percent of the children who qualified to be counted in this measure received dental services during this time period.[53] This score is higher than the HEDIS score achieved in 2013 by Medicaid reform plans of 42 percent which, until MMA, was the highest score ever recorded for this measure in Florida.

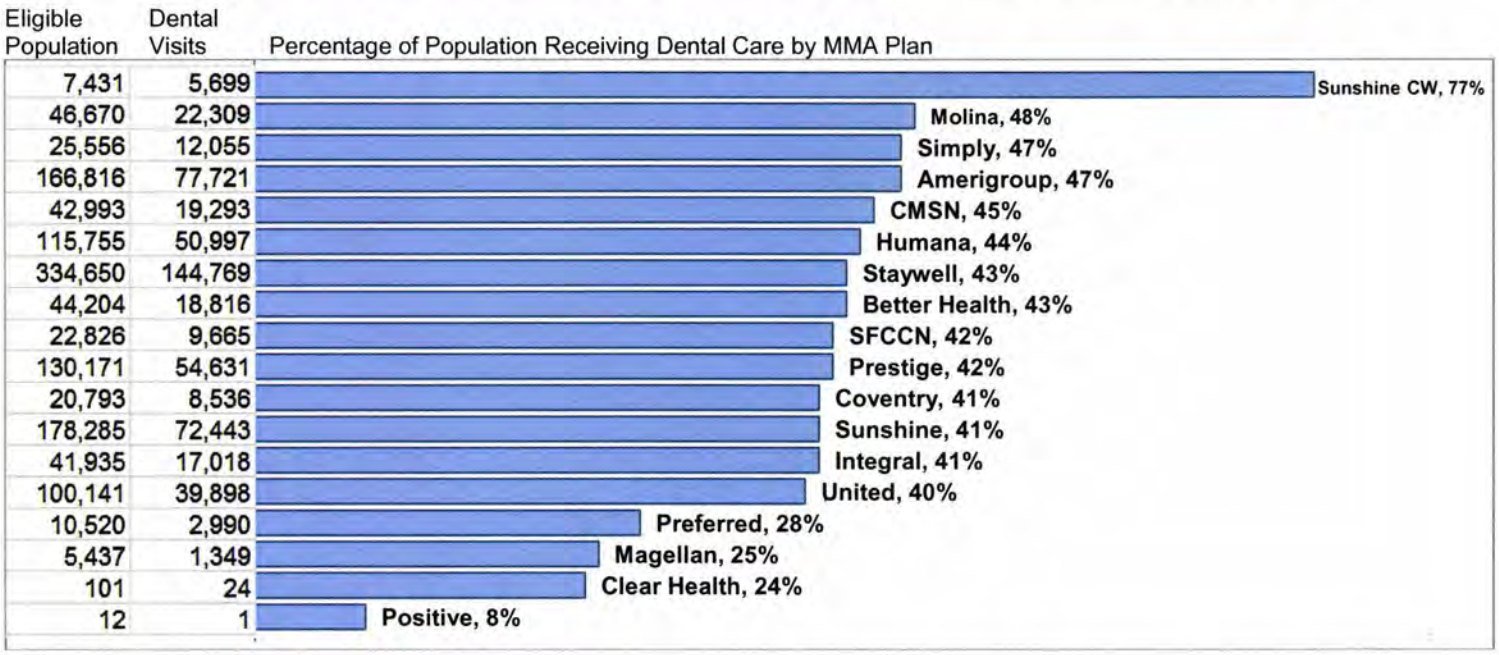
[43] During 2012, AHCA implemented the statewide PDHP program in Medicaid Area 9 on January 1; Areas 5, 6, and 7 on October 1; and Areas 1, 2, 3, 4, 8, and 11 (Monroe County only) on December 1, 2012.
[44] The original procurement period was December 1, 2011 through September 30, 2013. The program was renewed once, which extended the contracts through September 30, 2014.
[45] Agency for Health Care Administration, *Medicaid Prepaid Dental Health Plan Contract, Attachment II, January, 2012*, p. 60 (on file with Health and Human Services Committee staff).
[46] In calendar year 2013, both PDHPs failed to meet the required MLR and were required to repay AHCA an estimated $20 million. Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with Health and Human Services Committee staff).
[47] *Supra*, note 45 at 53-54.
[48] Id.
[49] Id. at 83. "Acceptable HEDIS score" was not defined in the PDHP contracts.
[50] National Committee for Quality Assurance, *HEDIS and Quality Measurement: What is HEDIS?*, available at: http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx (last visited February 5, 2016).
[51] *Supra*, notes 20; 54.
[52] Id.
[53] Id.

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years[54]

Time Period	MMA Plans	Reform Pilot Plans[55]	PDPHs (MCNA[56] and DentaQuest[57])
CY 2007 (Reported in 2008)	N/A	*15.2%*	N/A
CY 2008 (Reported in 2009)	N/A	*28.5%*	N/A
CY 2009 (Reported in 2010)	N/A	*33.4%*	N/A
CY 2010 (Reported in 2011)	N/A	*34.0%*	N/A
CY 2011 (Reported in 2012)	N/A	*35.3%*	N/A
CY 2012 (Reported in 2013)	N/A	**40.40%**	**40.92%**
CY 2013 (Reported in 2014)	N/A	**42.3%**	**37.04%**
MMA Year 1	**43.1%**	N/A	N/A

The chart does not reflect HEDIS annual dental visit scores for either the MMA plans or pre-MMA plans calendar year 2014 because 2014 was the MMA transition year, so the data is not representative of performance.[58]

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years by MMA Plan, MMA Year 1[59]



[54] Justin M. Senior, Florida Medicaid Director, Agency for Health Care Administration, *Florida Medicaid: Statewide Medicaid Managed Care*, PowerPoint Presentation to the House Health and Human Services Committee, January 2016. (Presentation on file with Health and Human Services Committee staff).

[55] The data for the Reform Pilot Plans indicate an initial improvement from 2007 to 2009, followed by relatively static numbers over the next few years from 2009 to 2011, followed by another improvement from 2011 to 2013.

[56] MCNA self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2010 to 2011 showing 34.8 and 35 percent, respectively. (Information on file with Health and Human Services Committee staff).

[57] DentaQuest self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2005 to 2011 showing an increase from 20 percent in 2005 to 39.1 percent in 2011. (Information on file with Health and Human Services Committee staff).

[58] For enrollees to be counted, for the purpose of the HEDIS score, they must have been in a single plan for at least 11 out of 12 months and must have been enrolled in that plan as of December 31, 2014. Neither the PDHP nor reform pilot plans remained in effect as of December 31, 2014. Additionally, data for the MMA plans 2014 calendar year is not accurate because the number of enrollees counted in the scores are artificially low. Due to the transition to MMA program throughout 2014, there were very few enrollees who had been in an MMA plan for the required time that could then be counted for the 2014 HEDIS score.

[59] Agency for Health Care Administration, *Florida Medicaid: Data Visualization Series*, https://bi.ahca.myflorida.com/t/FLMedicaid/views/DentalProfileMMAYear1/DENTALSERVICES-MMA?:embed=y&:toolbar=no&:display_count=no (last visited February 5, 2016).

Effect of the Proposed Changes

The PCS requires AHCA to provide a comprehensive report[60] on how dental services have been provided to Medicaid recipients in the state by MMA plans in the MMA program, statewide and regional Medicaid PDHPs, and the non-managed care state plan program prior to the MMA program.

The report must examine the provision of dental services by each delivery model using comparable measures applied to comparable data in 12-month data sets from audited data sources.[61] The report must document and compare each delivery model's effectiveness at:

- Increasing patient access to dental care;
- Improving dental health; and
- Achieving satisfactory outcomes for Medicaid recipients.

Additionally, the report must examine, by plan and in the aggregate, the historical trends of dental provider participation in plan networks.

The report is due to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016.

The PCS permits the Legislature to use the report findings to set the scope of minimum benefits under the MMA program for future plan procurements. Specifically, the Legislature may use report findings to determine whether to maintain dental services as a minimum benefit in the MMA program or to provide Medicaid dental benefits separate from the MMA program.

The PCS provides an effective date of upon becoming law.

B. SECTION DIRECTORY:

Section 1: Creates an unnumbered section of law relating to a report.
Section 2: Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA estimates a contract with an independent entity to assist in preparing the comprehensive report will cost $250,000.[62]

[60] The PCS grants AHCA the authority to contract with an independent third party to assist in the preparation of the report.
[61] This type of data set would include HEDIS scores. The new HEDIS scores for calendar year 2015 will be published in July 2016.
[62] *Supra*, note 6 at 9.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Medicaid Dental Services; creating an unnumbered section of law; requiring the Agency for Health Care Administration to provide a report to the Governor and the Legislature; specifying requirements for the report; providing for the use of the report's findings; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. The Agency for Health Care Administration shall provide a comprehensive report on the provision of dental services to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016. The agency may contract with an independent third party to assist in the preparation of the report.

(1) The report must examine the provision of dental services by managed care plans in the managed medical assistance program in part IV of chapter 409, and by statewide and regional Medicaid prepaid dental health plans and the non-managed care state plan program prior to the managed medical assistance program. The report must document and compare each delivery model's effectiveness at increasing patient access to dental care, improving dental health, and achieving satisfactory outcomes for Medicaid recipients. In preparing the report, the agency must use comparable measures applied to comparable data

in 12-month data sets from audited data sources. Additionally, the report must examine, by plan and in the aggregate, the historical trends of dental provider participation in plan networks.

(2) The Legislature may use the findings of this report in setting the scope of minimum benefits set forth in s. 409.973, Florida Statutes, for future procurements of eligible plans under s. 409.966, Florida Statutes. Specifically, the Legislature may take into consideration the data and findings of the report in making a decision to maintain dental services as a minimum benefit provided by managed care plans in the Medicaid managed medical assistance program, or to provide Medicaid dental benefits separate from the Medicaid managed medical assistance program or by some other delivery model.

Section 2. This act shall take effect upon becoming law.